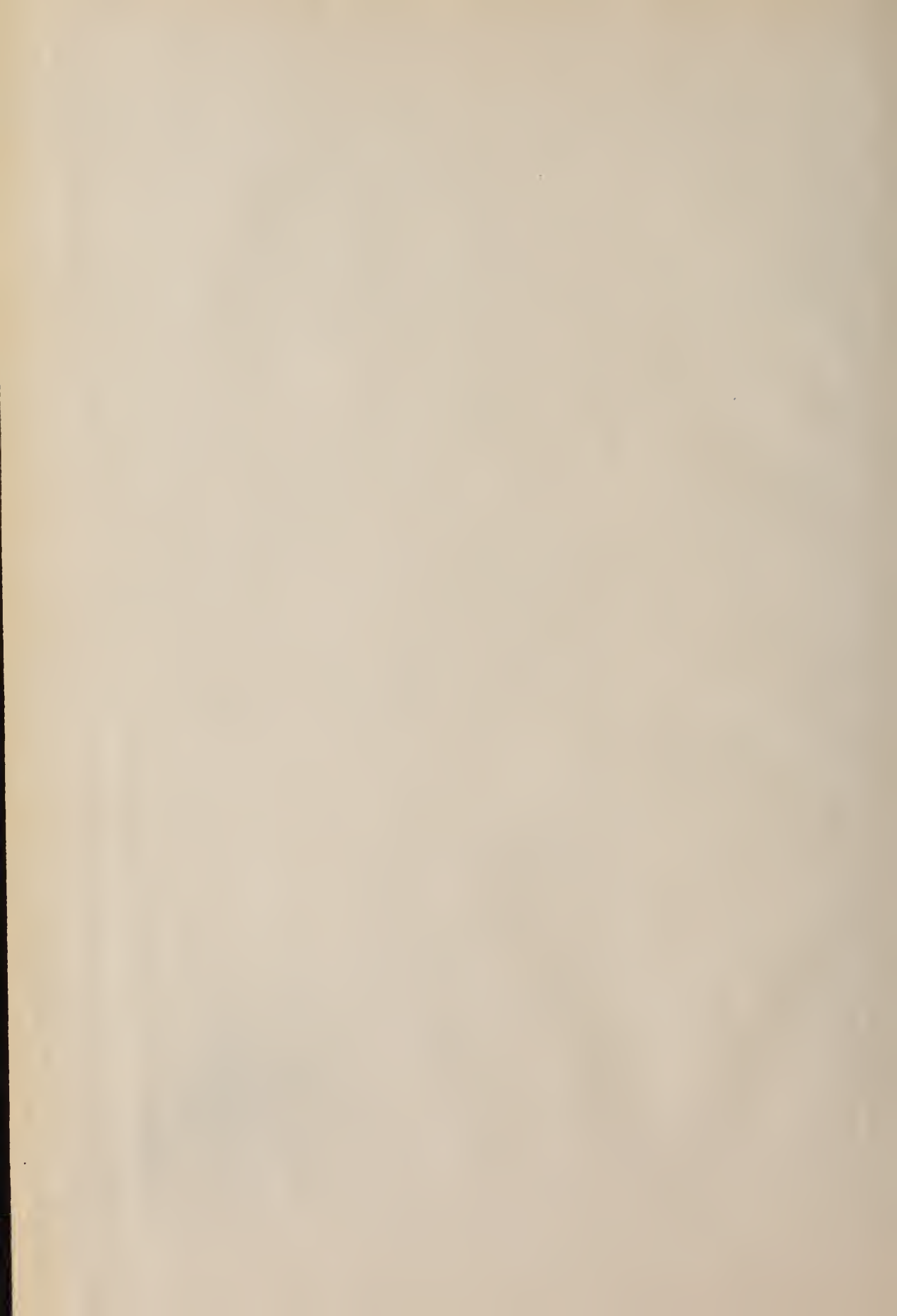


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Magnesium Trisilicate	50.0 mg.
Calcium Gluconate	65.0 mg.
Dicalcium Phosphate Anhydrous	100.0 mg.
Sucrose	600.0 mg.
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*Harding, F. E.: West. J. Surg. 52:31 (Jan.) 1944.

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Bibliography: 1. Humphreys, P., *et al.*: *Angiology* 3:1 (Feb.) 1952. 2. Russek, H. I.; Urbach, K. F.; Doerner, A. A., and Zohman, B. L.: *J.A.M.A.* 153:207 (Sept. 19) 1953. 3. Plotz, M.: *New York State J. Med.* 52:2012 (Aug. 15) 1952.

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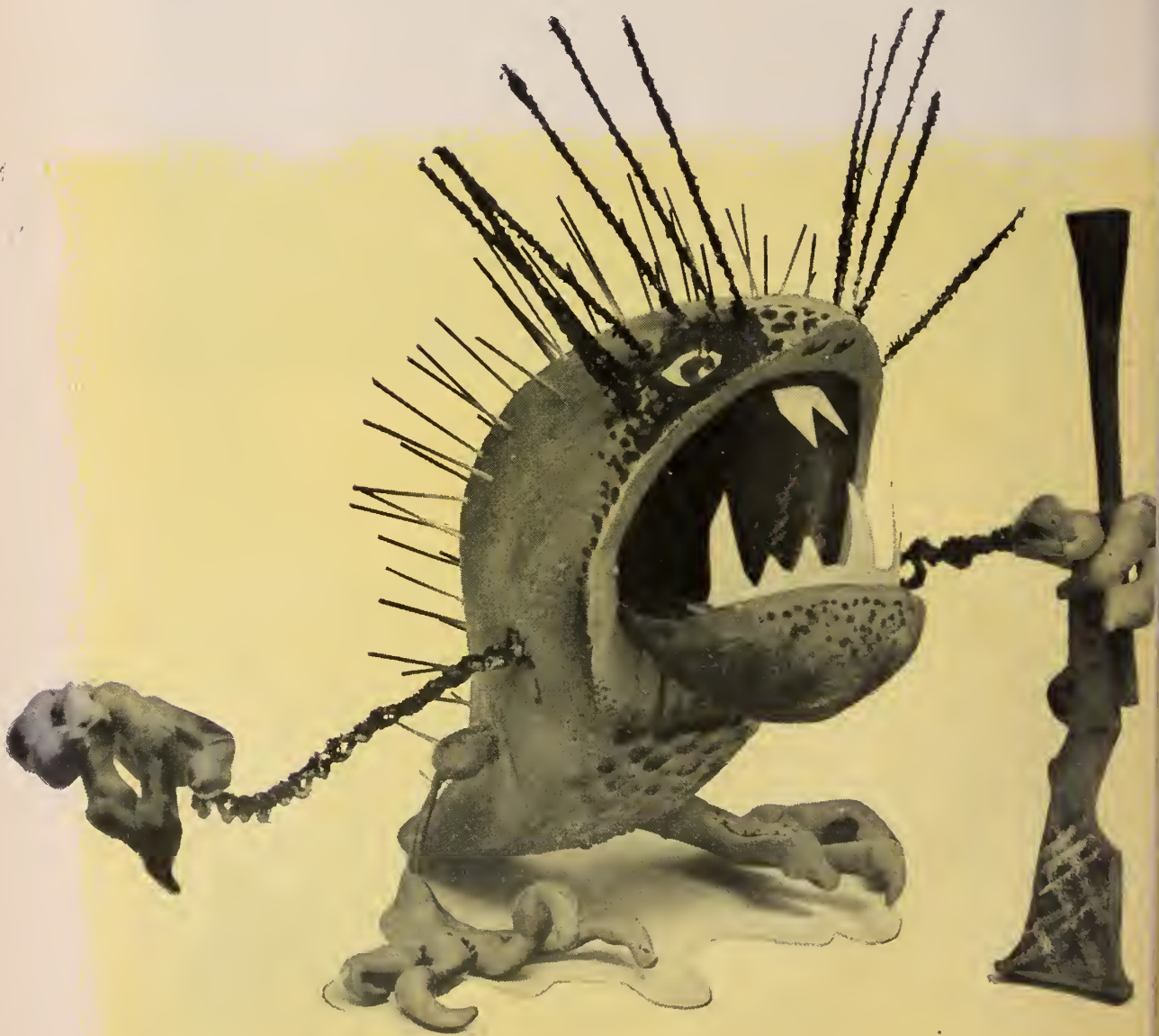
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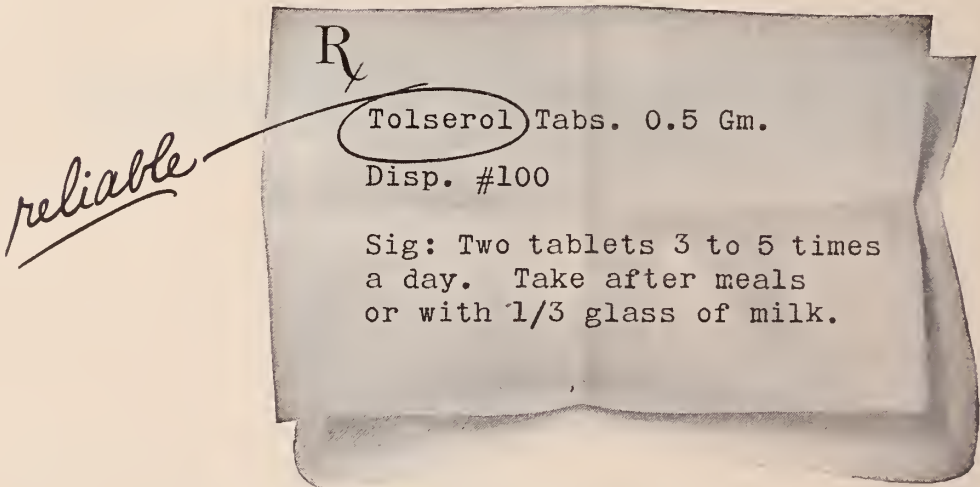
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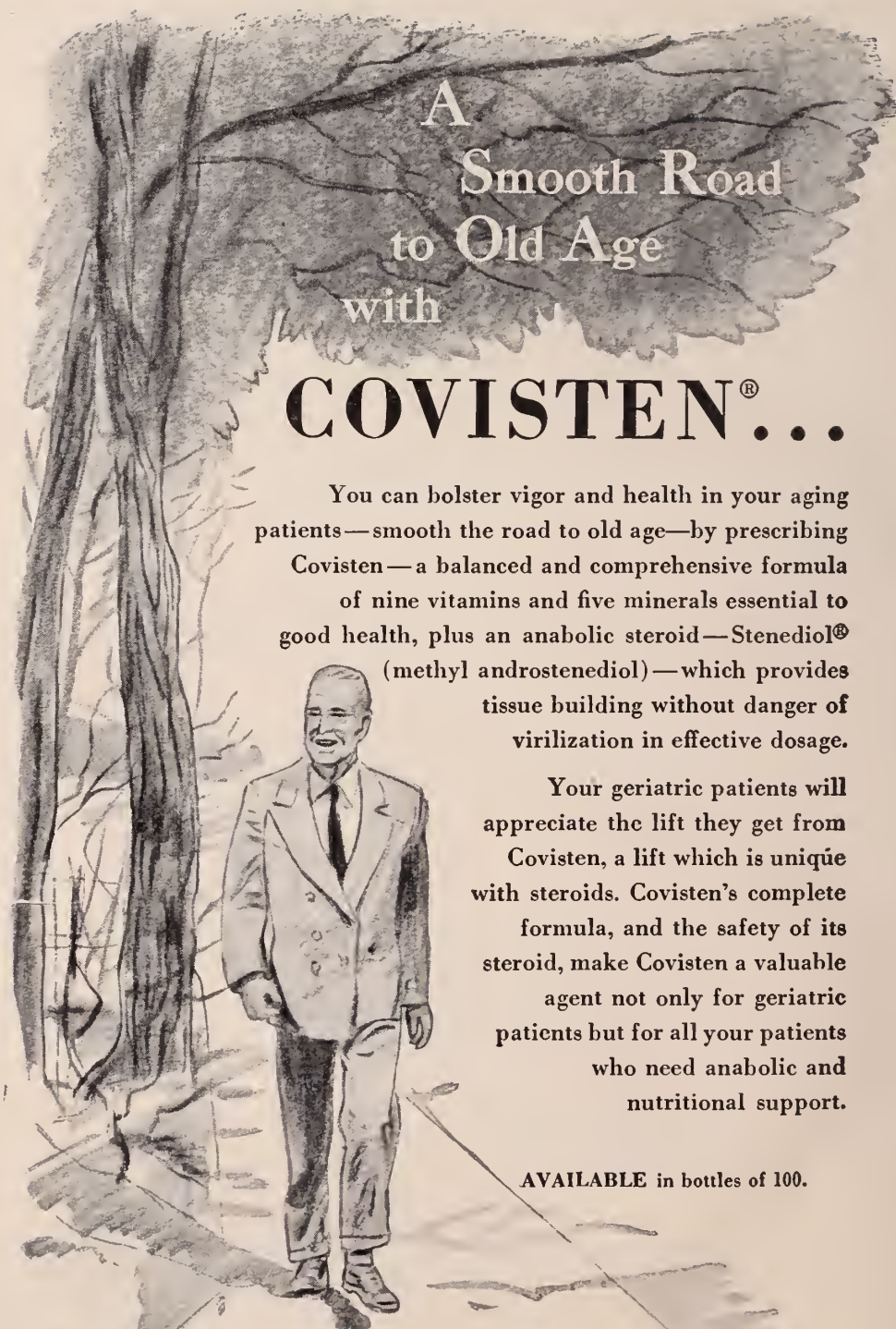
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For the immediate reduction of critically elevated blood pressure in hypertensive emergencies such as hypertensive states accompanying cerebral vascular disease, hypertensive crisis (encephalopathy), the toxemias of pregnancy. It lowers the blood pressure promptly, to any degree the physician desires,

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1. Kauntze, R., and Trounce, J.: Treatment of Arterial Hypertension with Veriloid (Veratrum Viride), *Lancet* 2:1002 (Dec. 1) 1951.

2. Wilkins, R. W.: Combination of Drugs in the Treatment of Essential Hypertension, *Mississippi Doctor* 30:359 (Apr.) 1953.



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Contrary to the concept that protein intake contributes to the genesis of hypertension and should be drastically reduced in therapy^{1, 2, 3} adequate protein nutrition today is considered essential for preserving maximal vigor and a sense of well-being in the hypertensive patient.³ Meat, once thought to be contraindicated, now is recognized as an important protein food in the dietary regimen in hypertension.

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But not only for its high content of biologically top-quality protein is meat a recommended daily food in the diet of the hypertensive patient. It also goes far toward satisfying the needs for essential B vitamins and minerals. Another important feature of meat is its outstanding taste appeal and its virtually complete digestibility.

1. Wilhelmj, C. M.; McDonough, J., and McCarthy, H. H.: Nutrition and Blood Pressure, *Am. J. Digest. Dis.* 20:117 (May) 1953.

2. Mann, G. V., and Stare, F. J.: Nutritional Needs in Illness and Disease, *J.A.M.A.* 142:409 (Feb. 11) 1950.

3. McLester, J. S., and Darby, W. J.: Nutrition and Diets in Health and Disease, ed. 6, Philadelphia, W. B. Saunders Company, 1952, pp. 519-524.

4. Levine, V. E.: The Blood Pressure of the Eskimo, *Federation Proc.* 1:121 (Mar. 16) 1942.

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"The results presented indicate that the oral penicillin suspension studied by us is a satisfactory antibiotic for the treatment of some of the common infections of the respiratory tract caused by β -hemolytic streptococci" ... and uncomplicated pneumonias of childhood.⁴



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Bicillin "oral suspension is palatable, was accepted without difficulty by all patients in both groups [children and adults] and was well tolerated."²



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REFERENCES

1. Cathie, I.A.B., and MacFarlane, J.C.W.: Brit. M. J. 1:805 (April 11) 1953.
2. Coriell, L.L., and others: Antibiotics & Chemotherapy 3:357 (April) 1953.
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REFERENCES

1. Freed, S. C. and Mizel, M.: Annals of Int. Med. June 1952
2. Dripps, R. D.: J.A.M.A. 139:148-150 (Jan. 15) 1949
3. Council on Pharmacy and Chemistry (Drug products used for obesity) (Prac. Phar. Ed) 8:436 (Sept.) 1947

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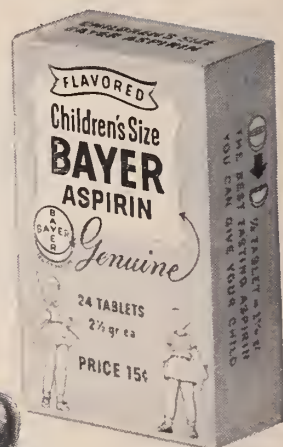
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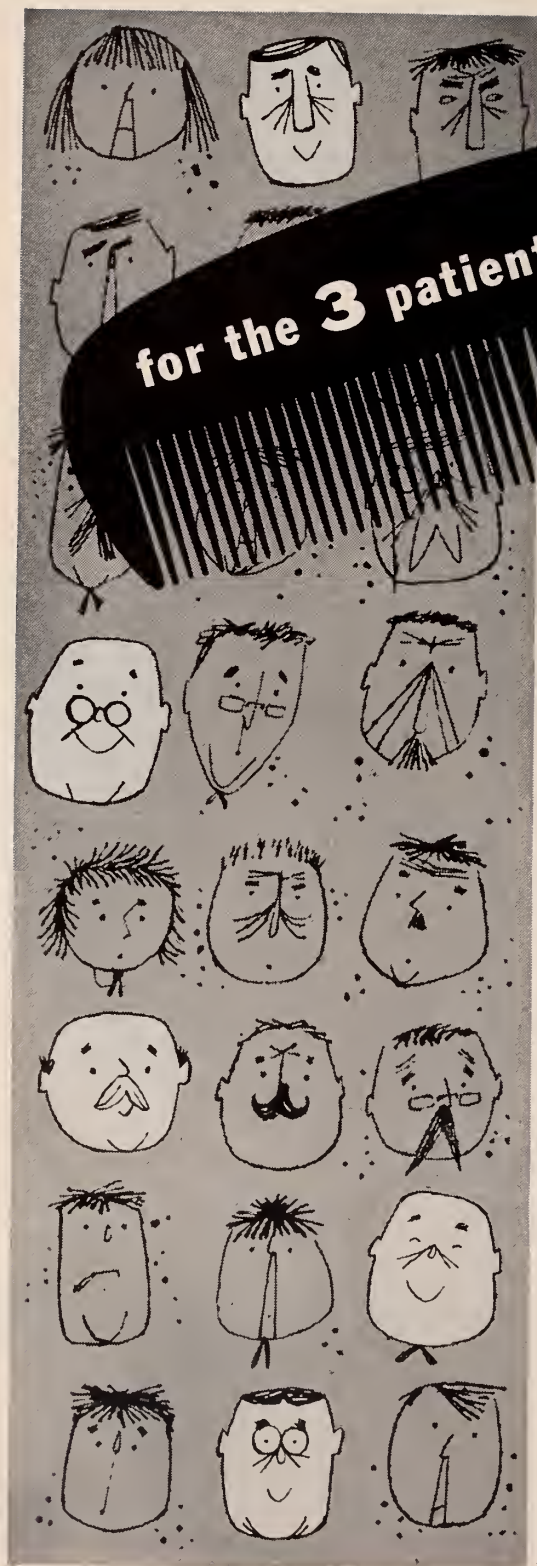
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1. Slepyan, A. H. (1952), Arch. Dermat. & Syph., 65:228, February. 2. Slinger, W. N. and Hubbard, D. M. (1951), *ibid.*, 64:41, July. 3. Sauer, G. C. (1952), J. Missouri M. A., 49:911, November.

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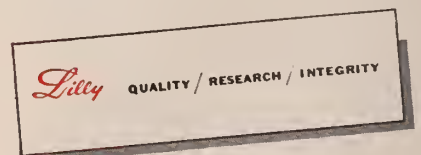
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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

The Old Year and the New

WITH this issue of the JOURNAL we begin our second half century as a medical publication. It is fitting at this time to review the progress of the past year.

Nineteen fifty-three saw the re-establishment in the JOURNAL of a department which had been dormant for several years. We refer to the correspondence section which was re-instituted to provide readers with a place to express their views on scientific articles, editorial matter, etc., and to bring items of medical society interest to the attention of our members. Another innovation this year was the addition of an announcement department to contain notices hitherto scattered throughout the JOURNAL. The space at the end of original articles, formerly used for this purpose, has now been reserved for scientific abstracts.

The JOURNAL, as is customary, published its annual reports issue in May and the proceedings of the 1953 annual meeting in August. This year also saw the present editor assume full editorship after six months as acting editor.

Dr. Henry A. Davidson, who for twelve years ably guided the editorial policy of this JOURNAL, resigned as editorial consultant in May.

The publication of our fiftieth anniversary issue in September marked the high point of this year's activities. This issue, marking the start of our fiftieth year of continuous publication and celebrating our status as one of the oldest state medical society journals in the country, presented a review of all phases of medical progress in New Jersey in the past fifty years. We are indebted to the contributing authors for their cooperation as well as to the officers of the Medical Society who made this special issue possible.

The Publication Committee, aware of its responsibility to provide members of our Society with a progressive and readable JOURNAL, presents, with this issue, some changes in typography and layout. They were effected only after lengthy study, consultation with experts in journal makeup, and careful consideration by the Committee. The comments of our readers are invited.

PUBLISHED MONTHLY SINCE 1904

Under the Direction of the Committee on Publication

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The Treponemal Immobilization Test

WHEN the laboratory reports a positive serologic test for syphilis, (STS) a diagnostic problem of major importance presents itself. If the patient gives no history of luetic infection, and denies antisyphilitic treatment, the physician must determine whether the positive test indicates a false positive, or latent untreated syphilis. Since untreated late syphilis may manifest itself by severe cardiovascular disease or serious forms of neurosyphilis, treatment is urgently required once a positive diagnosis is made. On the other hand, a false positive may indicate not only some benign condition such as the common cold, recent immunization, or convalescence from an acute exanthem, but may be the first evidence of more serious disease, including leprosy, infectious mononucleosis, malaria, lymphogranuloma venereum, or lupus erythematosus.

In an effort to resolve this puzzle, Nelson and Mayer¹ introduced the treponemal immobilization test (TPI test) in 1949, as a means of establishing the specific diagnosis of syphilis. Since then, the test has been subject to careful evaluation and investigation, particularly by the armed forces.

As recently reported from the Navy,² the TPI test was subjected to careful study and comparison. Sera from 496 untreated patients who had two or more positive standard serologic tests were examined. Of these, 43 per cent gave negative TPI tests, indicating a false positive reagin (STS) reaction. Fifty-two per cent had a positive TPI test, and the remainder gave inconclusive results. In a group of 148 patients who had received anti-luetic treatment because of a previous positive serologic test, 18 per cent had negative TPI tests.

The large number of false positive standard reagin tests—almost half of those tested—indicates an urgent need for the re-evaluation of routinely performed reagin tests and for a more critical interpretation of a positive serologic test in symptomless persons. This high incidence of false positives has been reported by other workers using a variety of reagin tests, including the VDRL, cardiolipin, and Eagle flocculation technics, as well as the standard Wassermann test.

THESE studies on the validity of serologic means for detecting latent syphilis point to a need for more exact diagnostic methods. This is essential if we are to avoid treating patients needlessly, not to mention the stigma attached to such a diagnosis and the difficulties of explaining it to a patient. It is of equal importance, however, to recognize that false positive serologic tests for syphilis may indicate other hidden, more serious disease.

Although progress has been made in the TPI test, and further investigations are under way, it still has not achieved a place in laboratories on a wide scale. At latest inquiry, the New Jersey Department of Health Laboratories had not included it as one of their diagnostic procedures. It is hoped that the test will prove its value in the near future, and that it will become available to practicing physicians throughout the state who are faced with the dilemma of evaluating a positive reagin test for syphilis.

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EUGENE REVITCH, M.D.

Newark

Epileptic Manifestations Resembling Psychiatric Disorders

Epileptic attacks do not always conform to typical grand mal or petit mal patterns. Less frequently seen forms of seizures are described. In their differentiation from purely psychiatric conditions the electroencephalogram is often diagnostic.

ABOUT 80 years ago the English neurologist J. Hughlings Jackson defined epilepsy as a manifestation of excessive neuronal discharge. This concept was confirmed by the introduction of clinical electroencephalography by Hans Berger in the early 1930's. Electroencephalography has, however, its limitations as a diagnostic tool. This is because normal interseizure electroencephalograms may be found in epileptics^{1,2} and abnormal epileptic-like patterns have been described by various investigators in non-epileptic prison inmates,^{3,4} in children with behavior disorders,⁵ in persons who committed motiveless murder⁶ and in relatives of epileptics. Furthermore the tracing is not always specific for a particular type of epilepsy except, perhaps, the three per second wave spike complex described by Lennox in the petit mal triad.⁷ The relative lack of specificity of the tracings, the existence of "borderline records" and the strong psychogenic orientation in modern psychiatry are frequently responsible for failure to recognize the less known, at times bizarre, paroxysmal phenomena whose epileptic nature is overlooked, and a purely psychiatric diagnosis is frequently given. These phenomena are as follows: (1) Aborted grand mal or psychomotor seizures; (2) Episodes of behavioral disorganization with or without dissolution of

consciousness; (3) Phenomena related to the activity of the autonomic nervous system with or without psychic manifestations; (4) Akinetic seizures.

ABORTED GRAND MAL AND PSYCHOMOTOR SEIZURES

Two misdiagnoses are frequent. First, patients with grand mal seizures, particularly under treatment, develop very short attacks without frothing at the mouth, falling down and other textbook symptoms. The whole seizure may be over while the patient is seated; usually, after a short period of hazy consciousness he is ready to resume his activities. Quite often these seizures are described by nurses and doctors as "petit mal." Yet the differential diagnosis is more than of academic interest since the drugs of the hydantoin group (Dilantin®, Mesantoin®) are specific for grand mal seizures but usually are contraindicated in petit mal attacks. The reverse is true for the drugs of the oxazolidine-dione group (Tridione®, Paradione®). The diagnosis should be made on the presence or absence of a three per second wave spike complex in the electroencephalograms.

Second, the aura may constitute the whole

seizure. Aura, which means breeze in Greek, was first described by Galen in one of his patients as tingling sensations in the extremities of one side preceding a grand mal seizure. Since Galen, all the "warning signs" of a seizure have been known as aura. However, if the seizure is viewed physiologically as a progressive invasion of the brain by the "excessive neuronal discharge" the aura will be no longer a "warning sign" of the seizure but the beginning of the seizure itself. It will be a clinical translation of the "excessive neuronal discharge" at the discharging focus. It is obvious that if, for various reasons, the discharge stops at the focus and fails to spread over the rest of the brain, the patient will experience only the aura without the rest of the seizure. This particular point was extensively reviewed by Nils Antoni⁸ to whose paper the interested reader is referred. The auras referable to the temporal lobe focus present a varied picture and are as follows: (1) olfactory hallucinations; (2) visual disturbances such as macropsia, micropsia, split in visual field and formed visual hallucinations; (3) feeling of depersonalization; (4) feelings of change of size and weight of various parts of the body.

No. 1. L. L., age 40 years, has had nocturnal seizures for several years. During the day he experienced various sensations which were evaluated as conversion hysteria and later schizophrenia. The fact that he had nocturnal seizures was not taken seriously since several electroencephalograms were perfectly normal. The patient, however was extremely preoccupied by his sensations and in despair kept an accurate diary for a period of three years in the hope that this would shed light on his condition. The description at times was so characteristic, that several excerpts of his diary will be transcribed here:

"Had that odd feeling again. Starts in the pit of the stomach and a sickening surge upward."

"On my travels began feeling funny. Children coming from school seemed rather hazy and not more than 50 feet away."

"While walking over to Mary's I had a rather uncomfortable few minutes. Started in the same way but with this difference. Fifth street is lined with large trees about every 30-40 feet. As I approached a tree it would vanish, then when I passed it would vanish, then when I passed it the next tree would vanish. I tried turning my head from side to side, but it did no good. Oh yes! Chills and goose flesh on arms with hair on arms erect. When I reached Mary's house found the same thing. Portions of her body invisible. But this finally wore off leaving me uncomfortable."

EPISODES of disorganized behavior with dissolution of consciousness are known at the present time under the name psychomotor epilepsy. Since a discharging focus in the temporal lobe is usually responsible for psychomotor attacks, auras referable to the discharge of this area are frequent. Gibbs, *et al.*⁹ described, in 1948, a more or less specific electroencephalographic pattern consisting of negative spikes in the anterior temporal region. The spike is either unilateral or bilateral and there is phase reversal in other leads if the ear lobe is used as a reference point. This pattern is more frequent when the record is taken in light sleep and may be missed in deep sleep or when the patient is awake. The attacks may be of a rather simple pattern such as repetitive aimless movements, or may consist of furor, assaultiveness or fugues. All of these activities, however, are amnesic and awareness during the attack is not preserved. Since many cases of psychomotor epilepsy also show interictal schizophrenic-like or psychopathic-like manifestations, and since the routine electroencephalograms may be either normal or without the specific pattern more commonly seen in sleep, diagnostic failures are more frequent than one may suspect.

No. 2. R. S., a 30-year old male, gave a history of irresponsible, shiftless and aggressive behavior since childhood. For several years he has had attacks of falling down, rolling on the floor with aimless flailing of the extremities and fighting those who approached him. Each seizure starts with an ill-defined sensation in the epigastrium and with a feeling of surge from his feet to his head. Then, shortly before the dissolution of consciousness, he experiences a vision of a candle surrounded by a halo. The halo gets smaller and then he has no longer any recollection of what follows. He has a feeling that by grabbing an object with his hands he is able to fight off an attack, but he fails to remember whether he had ever been successful in preventing one. The patient had had several admissions to mental hospitals and each time was given diagnoses such as schizophrenia, psychopathic personality or reactive depression. His attacks were considered by many observers as either hysterical manifestations or conscious deception. This impression seemed to be substantiated by five normal electroencephalograms. However, when the electroencephalogram was taken in light sleep the typical negative spike in the left anterior temporal area with phase reversal in other leads was elicited. The same pattern was obtained in a second record

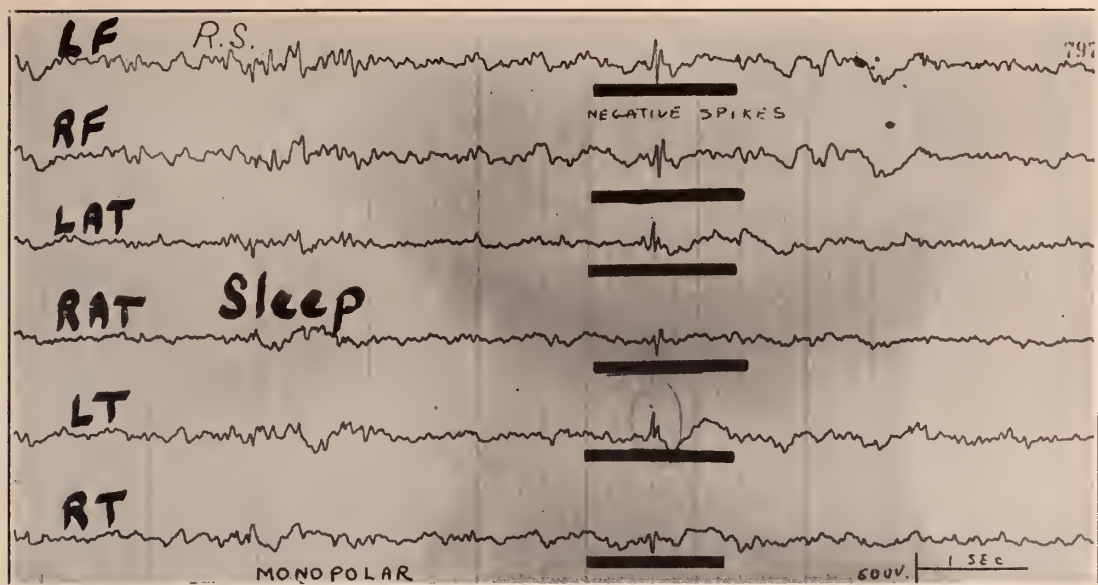


Figure 1. (R.S.) Chronic behavior disorder with attacks of falling, incoordinated movements and combativeness, with loss of consciousness. In light sleep notice negative spikes in the left anterior temporal and left temporal leads with phase reversal in other leads. Abbreviations: LF, left frontal; RF, right frontal; LAT, left anterior temporal; RAT, right anterior temporal; LT, left temporal; RT, right temporal. A wave above the base line is described as negative, below as positive.

taken in light sleep and thus the diagnosis of psychomotor epilepsy was established. (Figure 1)

The episodes of automatic disorganized behavior without loss of consciousness present a diagnostic problem of greater magnitude than the first group. This is due to the following: loss of awareness during a seizure is believed by many to be a prerequisite for the diagnosis of epilepsy; the seizures in question may be of longer duration than the classical types and the behavior is more coordinated and directed toward a goal than in the typical psychomotor attacks; the seizures in question may simulate emotional outbursts, due purely to psychogenic causes; affective changes such as depression may precede the acute attacks by periods of days. These episodes were known to the older observers in the pre-electroencephalogram era under the name of hystero-epilepsy and affect-epilepsy. The reader is referred to an exhaustive review of hystero-epilepsy and affect-epilepsy by Notkin.¹⁰ Cases reviewed by Notkin convey the impression, however, that the older authors also included in this category psychomotor attacks, cases of conversion hysteria as well as cases under discussion. In spite

of limitations of electroencephalography it has greatly contributed to the study of this type case. Waggoner and Bacchi¹¹ described, under paroxysmal convulsive disorder variants, patients with attacks of dizziness, headache, unreasonable anger, assaultive behavior and abdominal discomfort. Patients had abnormal electroencephalographic tracings and improved with anticonvulsive medication. Gibbs and Gibbs^{12,13} isolated, under the name of thalamic and hypothalamic epilepsy, paroxysmal behavior disorders characterized by rage reactions, weeping, and frequently autonomic phenomena such as palpitations and flushing. The behavior is directed toward a goal and consciousness is preserved. The electroencephalogram shows a rather characteristic pattern consisting of bilateral but not synchronous 6 and 14 per second positive temporal spikes.

No. 3. A. P., a 32-year old male, was referred for depression and irritability ending with destructive behavior. Past history included enuresis until the age of ten and a homosexual assault upon him when he was 6 years old. He enlisted in the Army in 1940 and was discharged in 1947 with the rank of corporal. He married in 1946, after a six months' courtship and has been a good provider, good hus-

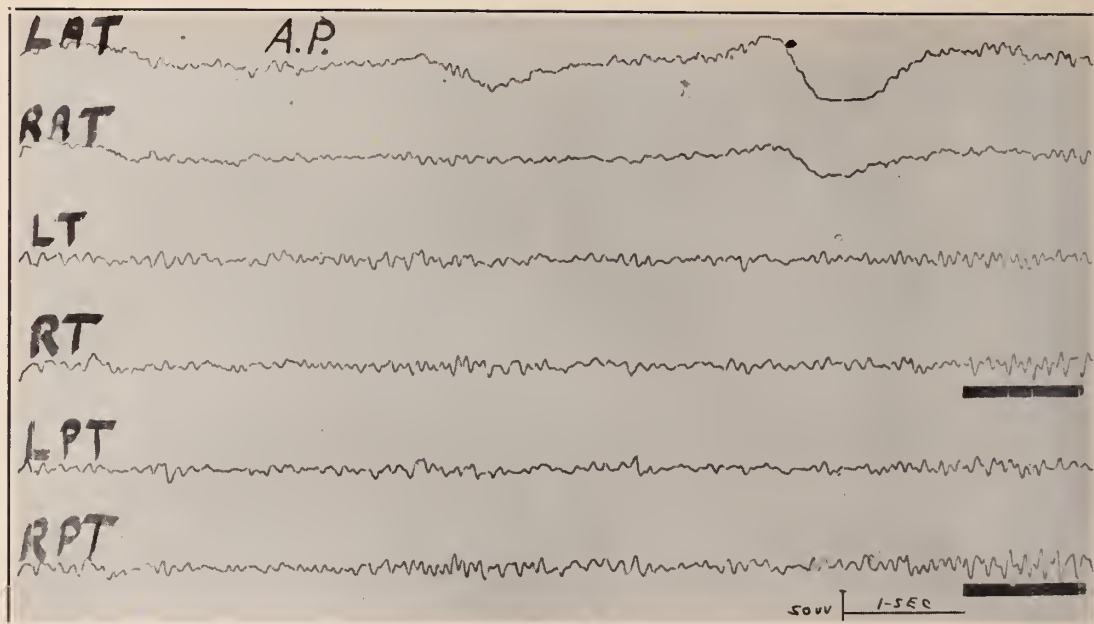


Figure 2. (A.P.) Attacks of aggressive behavior without loss of consciousness preceded and followed by depression. Notice six per second positive spikes in right temporal and right posterior temporal leads. Abbreviations: LPT, left posterior temporal; RPT, right posterior temporal.

band and good father, except for the episodes of affective changes and destructive behavior. His first attack was in 1947 and all subsequent attacks, which have been occurring two to three times a year, followed the same pattern. In the beginning the patient becomes depressed, moody, and irritable. He feels that his wife is picking on him and is too critical of his activities. He loses his appetite and prefers to stay by himself. He experiences a progressive increase of inner tension for a period of one week and then he has a feeling of "explosion" in the epigastrium and a feeling of bursting blood vessels. This is followed by a sudden outburst of violence such as smashing windows, hitting his head against the wall, etc. After approximately thirty minutes the patient quiets down. For a few days following the destructive outburst he complains of general malaise and nervousness. Physicians who saw him during the acute phase of the attack could converse with him and in general had the impression that his awareness was not impaired. The patient was able to remember his attacks, including the acute phase. A purely psychogenic condition was suspected and this impression was reinforced by a history of enuresis, homosexual assault upon him, etc. The electroencephalogram, however, showed nonsynchronous 6 per second positive spikes in the midtemporal and posterior temporal regions on either side. Although the 14 per second positive spikes were not observed, the diagnosis was thalamic and hypothalamic epilepsy and the patient was treated with anticonvulsive medication. (Figure 2)

No. 4. J. E., age 31, had had no difficulties and made an excellent adjustment until 1944 when his

ship received a direct hit by an enemy torpedo and he was stunned and thrown 15 feet away from the place where he had been standing. Following this experience he became irritable and intolerant of noise. Upon his evacuation to the United States he felt he could no longer control his emotions and he cried easily at the slightest provocation. He developed an urge to smash things and to scream. Once, while in a hotel room, he developed an attack of rage and violence during which he pulled hair out of his head, smashed the walls and it took four people to restrain him. He never had a recollection of the episode. He was discharged from the Navy in 1945 with the diagnosis, "no disease found." Later, however, the Veterans Administration awarded him 50 per cent disability and he was given a diagnosis of anxiety state. Since he made a poor adjustment to civilian life, he enlisted in the Army in 1947. During his two years of reenlistment he was frequently tense, restless, and finally obtained not a disability but a dependency discharge. Since his discharge from the Army in 1949 he has had attacks of irrepressible anger and long fugue states during which he left home and led an aimless, nomadic existence for several months. In addition to these symptoms he has developed attacks of violence, two to three times a year. Each attack is preceded by irritability, withdrawal, fear of getting into an argument, headaches starting in the back of the neck and spreading to the scalp, crying spells, a feeling of being "no good, fouled up and there is nothing I can do about it." After approximately one week of feeling that way he suddenly becomes extremely violent, smashing windows and dishes, but throughout his violence the awareness of environment is preserved. The attack

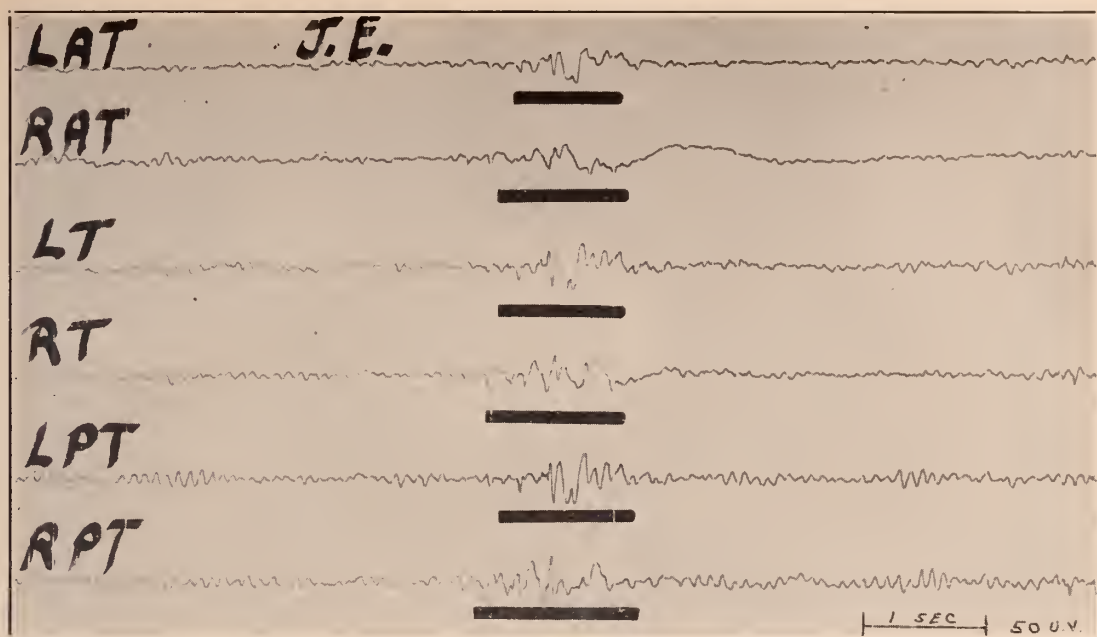


Figure 3. (J.E.) Attacks of aggressive behavior without loss of consciousness preceded and followed by depression. Notice burst of irregular hypersynchronous activity and negative spikes in left temporal leads with phase reversal in other leads.

ends with a feeling of guilt and suicidal thoughts. In addition to the attack of violence the patient has experienced occasional "fainting spells" without convulsions and sudden, uncontrollable and unprovoked attacks of weeping. An episode of depression lasting a few days follows an attack of weeping. Between attacks the patient is able to work and support his family. Since his electroencephalogram, taken on several occasions, showed bursts of irregular hypersynchronous waves and diffuse spikes and sharp waves in addition to negative spikes in the left midtemporal and posterior temporal regions with phase reversal in other leads (Figure 3) it became obvious that he had a variety of psychic seizures and was given an anticonvulsive medication. Shortly after treatment he spontaneously reported that his nightmares had disappeared. He had a few typical psychomotor attacks with loss of consciousness in the beginning, but later all of his attacks had characteristics similar to those described in case number 3 except that the electroencephalogram did not show the characteristic pattern described by Gibbs in hypothalamic epilepsy.

PHENOMENA RELATED TO THE AUTONOMIC NERVOUS SYSTEM

GOWERS,¹⁴ in 1907, described under the name "borderland of epilepsy" various paroxysmal disturbances such as attacks of vertigo, fainting spells and vago-vagal attacks. Under vago-vagal attacks he meant paroxysms of tachy-

cardia, feelings of suffocation, nausea, hot and cold flushes, pallor, sweating and shivering accompanied by fear and agony. Penfield,¹⁵ in 1929 described, under the name diencephalic epilepsy, attacks of flushing of the face, sweating, lacrimation, salivation, goose flesh, shivering and rise of blood pressure in a patient with a tumor compressing the anterior thalamic nuclei. In Wilson's textbook of neurology¹⁶ similar phenomena are described under the name "periventricular epilepsy" since it was felt that the "excessive neuronal discharge" took place in the nuclei of the fourth ventricle. It is, however, interesting to note that in Wilson's case after the termination of the attack "an overpowering nightmare of depression seized the patient, making him feel frankly suicidal." It is quite obvious that attacks of hyperactivity of the autonomic centers have been described under various names by earlier authors, and it is also obvious that these attacks were known to be connected frequently with affective changes. The dramatic phenomena described in these cases are also observed in attacks of anxiety. Since anxiety neurosis is of much more frequent occurrence than the autonomic

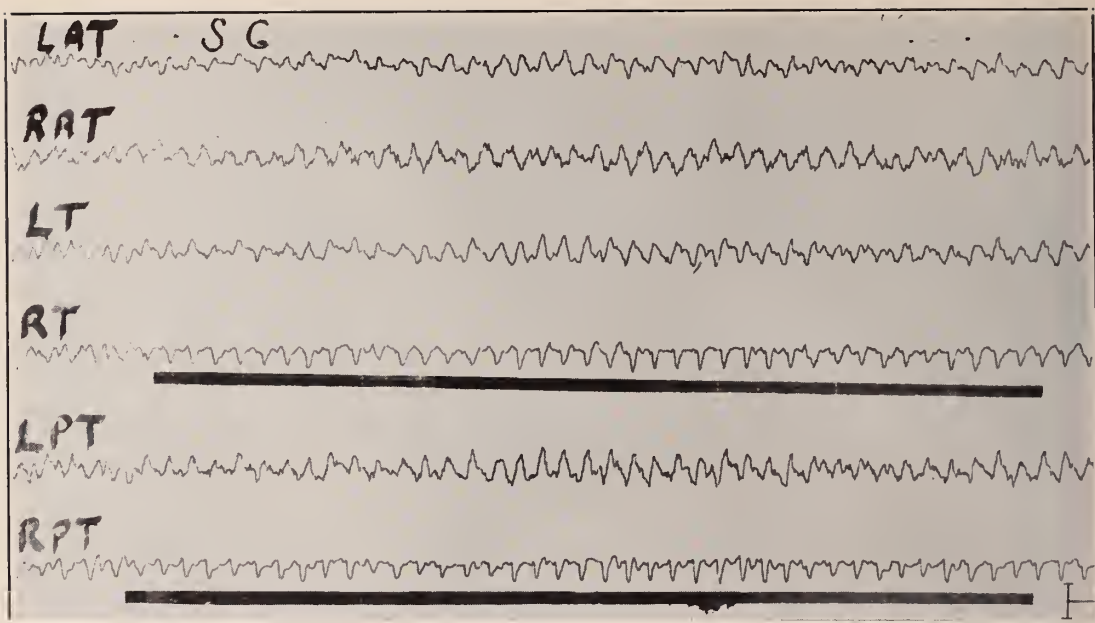


Figure 4. (S.G.) Attacks of anxiety, haziness of consciousness, tachycardia, flushing of face and neck, etc., and attacks of obsessive thinking. Notice five per second flat top waves with six per second positive spikes in the right temporal and right posterior temporal leads.

epilepsies, it is to be expected that the latter will be misdiagnosed and treated as purely psychiatric conditions.

No. 5. S. G., a 28-year old male, first developed symptoms in 1949 shortly after the accidental death of his brother. One day, while at work in the garage where he was employed as auto mechanic, he passed bloody urine. Shortly afterwards he experienced faintness, a feeling of impending doom and perspired profusely. The attack lasted just a few minutes, but the employer urged him to see a doctor, who found a temperature of 101 degrees Fahrenheit and gave him penicillin. Since then he has had rather frequent attacks consisting of an ill-described sensation in the occipital region and neck, general haziness of consciousness, goose pimples, cold and clammy extremities, rapid heart beat and a feeling of bloating and shrinking in the epigastrium. The attacks are occasionally preceded by flushing of the face and neck, which may be noticed by observers and is experienced by the patient as a burning sensation. A day or two before an attack the patient may feel restless and aggressive, but after the attack there is a feeling of depression and despondency lasting for two to three days. Independently of the attacks described above the patient has experienced compulsions to harm somebody with his dead brother's knife. The feeling creeps up on him for a day or two, during which time he tries to fight it off and on one occasion he even threw the knife out. His past history shows that he was shot through the chest during the war and a year before the first attack he sustained a brain concussion. The patient's attacks have dra-

matically improved with Dilantin.[®] He was free of attacks for a period of four months when he decided to stop taking the medication. The symptoms returned shortly afterwards. He previously carried the diagnosis of anxiety neurosis but psychotherapy administered for a year previously failed to improve his symptoms. The electroencephalogram was conspicuously abnormal (Figure 4). There were long runs of flat top 5 per second waves with 6 per second positive spikes, particularly prominent in the right midtemporal area, and more pronounced during and after hyperventilation.

AKINETIC SEIZURES

AKINETIC seizures consist of sudden loss of postural control, during which the patient collapses, falling to the floor. Lennox included the akinetic seizures in the petit mal triad.⁷ However, the 3 per second wave spike complex is not as characteristic and drugs of the oxazolidin group are not as specific for akinetic seizures as for the two other members of the triad (myoclonic seizures and absence of pyknolepsy). The myoclonic epilepsy and absence are always genetic, whereas akinetic seizures may be due to subtentorial lesions, encephalitis and ischemia of the brain stem. The clinical manifestations may be confused with cataplexy, syncope or conversion hysteria. The cataplectic

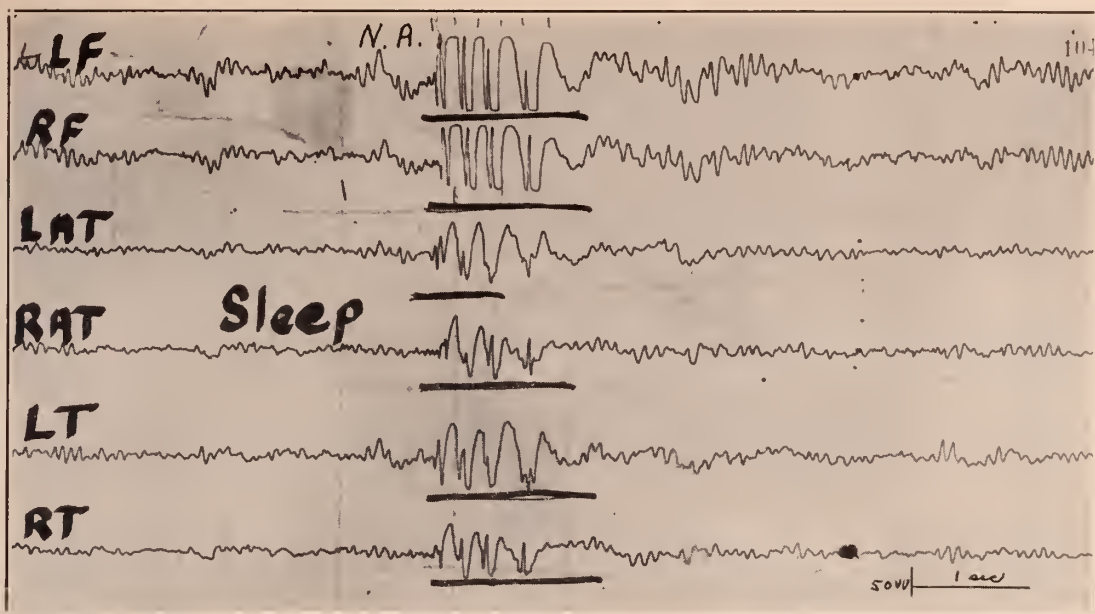


Figure 5. (N.A.) Attacks of akinetic seizures. Notice spike wave complex in all the leads.

attack, however, should be eliminated on clinical grounds, since it occurs during an emotional stimulus, such as laughter and is usually associated with narcolepsy. The cause of syncope should be sought through various tests, such as carotid sinus stimulation, 5 hour sugar tolerance test (a 2 or 3 hour sugar tolerance test may be misleading since the curve may reach the hypoglycemic level in the 4th or 5th hour only) and studies for cardiac disease, variations of blood pressure, etc. The reader is referred for a detailed discussion of syncope to the monograph by Engel.¹⁷ Electroencephalography, in spite of its limitations may be a very valuable diagnostic tool, particularly if the 3 per second wave spike complex is elicited.

No. 6. N. A., a 31-year old male, was in good general condition until July 1952 when his left hand was mutilated by the propeller of an onrushing plane. A month later, while bending down to shine his shoes he suddenly experienced a feeling of light-headedness and fell down on his face. He remained unconscious for several minutes and was taken to an army hospital, where the doctor told him that he suffered from "worries" and "shock." Since that time, however, he has had two to three short similar attacks a year. There is a history of convulsions in infancy, otherwise the past history is non-contributory. When examined his neurologic and physical examinations were negative, carotid sinus test and 5 hour sugar tolerance test were also normal. Conversion hysteria was suspected and

a battery of projective tests seemed to point to it. This was accepted as the diagnosis, particularly when several routine electroencephalograms showed a perfectly normal tracing. However in light to moderate sleep induced by 0.2 gram (gr. 3) of secobarbital orally, a very typical 3 per second wave spike complex was elicited in all the leads (Figure 5). The sleep electroencephalogram was repeated on 3 different occasions and each time a similar pattern was obtained. The diagnosis was changed then to akinetic epilepsy.

COMMENT AND SUMMARY

IT WAS obvious, even to the earlier investigators, that not all epileptic phenomena can be fitted into the three classical types and that typical seizures may be modified to such an extent that they may pass unrecognized. Paroxysmal phenomena involving the activity of the autonomic nervous system, psychic functions or both, as well as akinetic attacks, are at times serious problems in differentiation from various purely psychiatric conditions. Electroencephalography as a diagnostic tool has its limitations, since epileptic-like activity can be found in non-epileptics and on the other hand, normal interseizure electroencephalograms are found in some epileptics. In some instances, however, the electroencephalogram does not yield satisfactory results because only routine records are taken, without the benefit of activation

methods such as sleep. Of 6 cases presented in this study, number two and six have had normal routine electroencephalograms on several occasions. Yet in sleep a typical psychomotor pattern was found in number two, and a 3 per second wave-spike pattern characteristic for petit mal triad in number six. A combination of autonomic and psychic phenomena is frequent and there are apparently many transitional forms with quantitative differences. Thus patient number one, during auras referring to a temporal focus discharge, experienced piloerection. Number five, whose autonomic phenomena were prominent, experienced a feeling of depression before and after the attack and

in addition had episodes of obsessive thinking. In the seizures characterized purely by psychic phenomena, various transitional forms between cases with complete dissolution of consciousness and relative preservation of consciousness are found. Case four, for instance, experienced seizures with complete dissolution of consciousness and also with relative preservation of awareness and memory. Whether the affective changes preceding and following the attack should be considered as part of the seizure or purely psychogenic manifestations can be disputed. However, their constancy, order of occurrence and relief by anticonvulsive medication seems to point to the former.

82 Clinton Avenue

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Mixed Embryonal Tumors of the Kidney*

Wilms' tumor, the major renal malignancy of infants and children, is comprehensively discussed. Early recognition and combined surgical and x-ray therapy are advised. Experiences in 10 cases are outlined.

MIXED embryonal tumors of the kidney are practically the only renal tumors of childhood. They are usually unilateral, but occasionally may be bilateral.¹ Mirror incidence has been reported in identical twins.² Trauma,³ although not causative, may lead to their discovery. In two hospitals with a total bed capacity of about five hundred, ten such cases have been seen during the past sixteen years. The patients ranged in age from a newborn infant to a nineteen-year old girl; but, except for the last, all patients were under six and three were one year old or younger. Six were male, four were female. The right kidney was involved in six cases, the left in four. These figures are of little statistical importance but they agree fairly well with those reported in the literature. Allen¹ reports that these tumors comprise twenty to twenty-five per cent of all malignant tumors of childhood and are second in incidence only to neuroblastomas. One tenth of one per cent of 16,565 admissions to Memorial Hospital in New York were Wilms' tumors.

SYMPTOMATOLOGY

As is true of cancer anywhere in the body, early growths produce no symptoms. When the tumors originate within the draining portion of the urinary tract, hematuria may occur so early that early recognition and diagnosis are sometimes possible. However, since renal embryomas are cortical tumors, hematuria is

not usually an early sign and, consequently, may be of grave prognostic importance. A palpable and frequently visible mass is the most usual reason for suspecting renal tumors in childhood. Fortunately, these tumors occur at a time in life when patients are under the most careful scrutiny by pediatricians and parents; unfortunately, the tumor growth is so rapid that when first seen a huge mass may already be present or a patient may be watched too long, until the reality of the tumor becomes obvious. Such a patient happily is still alive eleven years following nephrectomy. This is case number one; on October 25, 1941, a rounded mass was discovered in the right side at the umbilical level. The mass was again examined on November 8, November 15, and November 22, and was referred for urologic consultation on November 25. Cystoscopy and pyelogram at this time confirmed the diagnosis and nephrectomy was done within twenty-four hours. All of the ten cases in this series had a palpable abdominal mass when first seen. In most, the mass was very large, sometimes occupying half the abdomen. Hematuria was present in four cases, accompanied by pain in two and was painless in two. In one case, number 6, a left sided tumor was mistaken for splenomegaly.

If proper methods are used, the diagnosis of renal embryoma should be made easily. Any

* Presented before the Section on Urology, May 18, 1953, at the Annual Meeting of The Medical Society of New Jersey, Atlantic City.

abdominal mass in a child should be considered a Wilms' tumor unless proved otherwise. Once a mass is identified, it is probably wise to manipulate it as little as possible, as external palpation by many examiners may spread the tumor. Within twenty-four hours urinalysis, blood studies, chest x-ray, intravenous pyelograms and, if necessary, retrograde pyelograms should establish the diagnosis and differentiate the tumor from adrenal neuroblastoma, polycystic kidney, hydronephrosis or splenic enlargement. Barium studies of the gastro-intestinal tract are rarely necessary. Papanicolaou⁴ stains have apparently not been employed in diagnosis.

PATHOLOGY

RENAL embryomas are rapidly growing cortical neoplasms, generally circular expanding masses with a pseudocapsule occurring centrally or at the upper or lower poles of the kidney. The tumor mass may even compress the kidney into a thin strip. Most of the specimens are yellowish-white, grayish-white or pinkish-white in color. Although some are solid, most are lobulated and some are cystic. At times mucoid areas are prominent. The consistency is almost universally soft and friable.

Microscopically there is extreme variability in the type of tissue found. Probably the most characteristic appearance is that resembling the renal blastoma in which abortive atypical tubules and glomerular structures are seen. Other portions of the tumor may contain other tissues of mesodermal origin, such as connective tissue, spindle cells arranged in solid masses and rosettes, lymphatic tissue, angiomatous tissue, muscle (smooth and striated), fat and cartilage. Frequently several types of tissue can be seen in one field. In those cases which have been irradiated previously, extensive hemorrhage and necrosis are often found. In one case, number 9, these changes were so extensive that pathologic diagnosis was almost impossible. However in most cases, although considerable destruction had been caused by the x-ray, viable cells were still present. This finding is of considerable therapeutic importance.

Renal embryomas metastasize to the liver,

lungs and regional lymph nodes but do not invade the bones as do the neuroblastomas. The brain, adrenals and other organs may be involved. In only two of the ten cases in this series was there clinical evidence of metastasis when first seen but five had tumor extension at the time of operation.

CASE REPORTS

No. 1. D. G., a one-year old boy, was found by his pediatrician to have a right abdominal mass during a routine physical examination. The patient was observed for one month before urologic consultation was requested. At this time, a diagnosis of renal embryoma was made by retrograde pyelography. The right kidney was about three times the size of the left and the pelvis was enlarged. The minor calyces were blunted. The right ureter was abnormal in its course, extending almost at right angles from the kidney pelvis, passing over the midline and then angling sharply downward. It was felt that this distortion indicated a tumor at the lower pole of the right kidney.

Retroperitoneal translumbar nephrectomy was done on November 26, 1941. The pathologic study was reported as renal embryoma. Irradiation was given postoperatively.

The specimen consisted of a kidney, the lower half being replaced by an encapsulated tumor measuring 6 x 7 centimeters. On section the tumor was yellowish-white and was soft and friable. No evidence was found of any cysts or bony material within the tumor.

Microscopic appearance of this tumor revealed undifferentiated cellular stroma, separating rather large groups of atypical and dilated tubules. The tubules were lined by atypical epithelium in which the cells contained hyperchromatic nuclei and some mitotic figures. The stroma consisted of myxomatous connective tissue and some muscle. No definite cartilage could be found in these sections. In some areas, embryonic glomerular tufts could be found. The tumor was surrounded by a thick connective tissue capsule and there did not appear to be any invasion into the surrounding kidney. This boy is alive and well eleven years after nephrectomy.

No. 2. W. M., a six-month old white boy, was admitted with a mass in the left flank extending almost to the iliac crest. Subcutaneous urograms demonstrated a normal right kidney and a non-functioning left kidney. A large oval mass was present on the left side, extending 2.5 cm. to the right of the midline at the level of the third lumbar vertebra. Chest films were negative.

Retroperitoneal translumbar left nephrectomy was done on January 30, 1947, three days after admission. A Sweetser type incision was employed.

The pathologic report showed Wilms' tumor of the left kidney, gland cell variant. Sections taken from around the hilus of the kidney, including the blood vessels and ureter, showed nests of malignant cells identical with those seen in the kidney tumor.

Deep x-ray therapy was given postoperatively to a total of 3000 roentgens. This boy is alive and well over five years postoperatively.

No. 3. J. W., a nineteen-year old female, was admitted because of a dull ache in the right lower abdominal quadrant and hematuria for two or three days, eight days before admission. She had also noticed a mass in the right side of the abdomen. A diagnosis of a renal tumor was made by retrograde pyelography.

Retroperitoneal translumbar nephrectomy was done on April 22, 1950. Convalescence was uneventful.

The pathologic diagnosis was Wilms' tumor of the right kidney; regional lymph nodes showed no involvement.

Deep x-ray therapy was given and this girl is alive and well three years following operation.

No. 4. J. C., a four-year old boy, was admitted because of painless hematuria. A mass the size of a man's fist was found in the region of the right kidney. Retrograde pyelography demonstrated a large filling defect in the right kidney.

On March 6, 1936, retroperitoneal translumbar nephrectomy was done. Convalescence was uneventful. Deep x-ray therapy was given postoperatively.

The pathologic report indicated Wilms' tumor, right kidney.

This boy is alive and well, seventeen years having elapsed since his operation.

No. 5. B. B., a fifteen-month old white male, was admitted because of gross hematuria of five days' duration. A firm, lobulated, nontender mass was visible and palpable in the right upper quadrant. Several small submandibular nodes were felt. Diagnosis was made by retrograde pyelography.

Retroperitoneal translumbar nephrectomy was done on April 8, 1948, three days after admission. The pathologic diagnosis was renal embryoma.

Deep x-ray therapy was given, 3000 roentgens. Death occurred five months later and no autopsy was performed.

Here the prognosis was poor because tumor extension had already taken place at the time of operation.

In this group of five cases treated by immediate operation followed by x-ray the three in which there was no preoperative tumor spread survived and one survived in spite of it. In one with preoperative metastasis, death occurred.

In the next group of five cases, preliminary x-ray treatment was given.

No. 6. J. A. L., a five-year old girl, was admitted on April 30, 1944, because of an "upper respiratory infection, pain in the abdomen and a history of splenomegaly." A mass was palpable in the left abdomen, extending from the ribs to the umbilicus and from the flank to beyond the midline. Because

of an erroneous diagnosis of splenomegaly, five months elapsed before pyelograms done outside the hospital revealed renal tumor. X-ray therapy was given and this was followed by retroperitoneal translumbar nephrectomy. At this time a mass of glands extended from the renal hilum up into the chest.

Pathologic diagnosis demonstrated Wilms' tumor.

Eight months later lung metastases were present and death occurred nine months following nephrectomy.

A five-month delay in accurate diagnosis made the prognosis poor. Metastases were already present at the time of operation.

No. 7. C. S. S., a 20-month old boy, was admitted because of listlessness and irritability of six weeks' duration. A hard, irregular mass was seen and felt in the left side of the abdomen. A diagnosis of Wilms' tumor was made by intravenous pyelography. These showed the right calyces and pelvis to be normal although there was a slight rotation of the pelvis. On the left, a mass was seen. The lower portion of this mass contained the visible intrarenal structures. There were two groups of calyces, lower and middle. Upper calyces on this side were missing. The upper margin of the pelvis appeared a little straight and flattened. Chest films were negative.

Deep x-ray therapy was instituted, the patient receiving sixteen hundred roentgens. Several weeks later, left nephrectomy was attempted but was not carried out because of large retroperitoneal metastasis. Biopsy of the tumor showed Wilms' tumor.

Death occurred one month following operation.

No. 8. R. E. M., a four and one-half-year old girl, was admitted in July, 1949, with a diagnosis of acute appendicitis and an appendectomy performed. Two months later there had been no improvement since operation, and the child was re-admitted because of nausea, vomiting and listlessness. On examination, a large mass was found filling the right abdomen. A diagnosis of Wilms' tumor was made by retrograde pyelography. Films showed the soft tissue mass in the upper abdomen. The left kidney was entirely obscured by gas and the right was not well visualized, being obscured by the mass or being involved in it. X-rays of the chest and skull were negative.

Preoperatively the patient received x-ray therapy, 400 roentgens, which reduced the mass fifty per cent. A translumbar retroperitoneal nephrectomy was done eight days later. Metastases were present in the perirenal fat. Pathologic report showed Wilms' tumor.

Postoperative irradiation was given, 800 to 1000 roentgen units to each of two fields. There was improvement for about nine months but, eighteen months following operation, death occurred due to hemoperitoneum from rupture of a neoplastic mass. Autopsy also showed pleural and peritoneal implants.

Here again delay in diagnosis rendered the prognosis poor.

No. 9. B.B.S., a newborn male infant, was found, in January 1943, to have bloody clots with mucus when urinating and a mass in the left flank. Chest films were negative. Pyelograms were made with subcutaneous saline and diodrast. The right kidney pelvis was very well outlined. In the left kidney pelvis only a trace of diodrast could be found. Part of the fluid had already descended into the bladder. From this examination, a diagnosis of Wilms' tumor of the left kidney was made.

Eight hundred roentgens of irradiation were given preoperatively.

Transperitoneal nephrectomy was done on the twenty-fifth day of life. Severe projectile vomiting persisted postoperatively so the baby was returned to the operating room and a Ramstedt operation was done for pyloric stenosis.

Following the second operation, the patient became weaker and finally expired on the seventh postoperative day. Autopsy showed areas of intestinal necrosis.

This tumor was so thoroughly destroyed by x-ray that an accurate pathologic diagnosis was impossible. It is also possible that irradiation may have been responsible for death.

No. 10. N. M., a two-year old girl, was admitted on July 18, 1950, because of a mass in the left flank of one month's duration. Retrograde pyelograms and chest films were done with a diagnosis of Wilms' tumor on the left, with bilateral pulmonary metastases.

X-ray studies showed a large oval mass in the left side of the abdomen, which displaced the stomach upward and the ureter to the right. Right renal shadow appeared normal. No calcification was noted.

After injection of dye, films showed a normal pelvis and calyces on the right. The pelvis on the left was dilated and the calyces elongated, compressed and distorted, consistent with renal neoplasm.

Retroperitoneal translumbar nephrectomy was done followed by postoperative irradiation of the lungs. The pathologic report was Wilms' tumor.

Following the first course of radiotherapy, 750 roentgens, to the lung fields, the condition regressed and they were no longer apparent by roentgenography. In three months, however, the metastases recurred so that a second course of x-ray therapy to both lungs was given, 1400 roentgens.

By January 31, 1951, five months following the nephrectomy, dyspnea developed, which became progressively worse. Cyanosis developed on the fifth day and the child expired six months following nephrectomy.

Autopsy showed residual tumor in the region of the left renal pedicle, metastases of the tumor to the lungs and pulmonary fibrosis due to x-ray therapy, dilatation of the right side of the heart,

fluid in the pleural and peritoneal cavities and passive congestion of the liver.

TREATMENT AND RESULTS

EMBRYONAL mixed tumors may be treated by irradiation alone, by nephrectomy alone, by nephrectomy with preoperative and postoperative irradiation or by nephrectomy with postoperative irradiation.

Dean⁶ reports five cases out of twenty apparently cured by irradiation alone. Few urologists today advocate this method of treatment.

In 1950, Harvey⁷ published 716 cases collected from the world's literature. Of the 444 cases in which the type of treatment was recorded, there was a survival rate of ninety-seven or 21.9%. These are broken down into the following categories:

Treatment	Number of Cases	Number Surviving	Percent
Irradiation alone	63	10	15.8
Surgery alone	180	28	15.5
Preoperative irradiation and surgery	27	5	18.5
Surgery and post-operative irradiation	109	33	30
Preoperative irradiation, surgery and post-operative irradiation	65	21	32.3

In this group, those treated by preoperative irradiation, surgery and postoperative irradiation fared slightly better than those treated by surgery and postoperative irradiation. The difference, however, is slight.

In 1950, Gross⁸ and Neuhauser reported the statistics from the Boston Children's Hospital. Here, between 1914 and 1930, there were four cures in twenty-seven cases, a survival ratio of 14.9%. The operative mortality alone was 23%.

From 1931 to 1939, Dr. William Ladd⁹ introduced changes in technic, anesthesia and aftercare and, during this period, achieved a 32.2% survival rate with no operative mortality.

From 1940 to 1947, postoperative x-ray was given in addition to surgery and, in a group of thirty-eight cases, Gross attained a survival

of 47.3%, eighty per cent in patients below twelve months and 43.3% in patients above twelve months of age.

Many surgeons have advocated preoperative irradiation on the grounds that the tumor can be remarkably reduced in size, making surgery technically easier. Ladd opposed this approach on two counts; first, because the delay in operation permitted the possibility of tumor spread and secondly, because he felt that the tumor might spread as a result of the necrosis and liquefaction produced by x-ray. Gross, however, influenced by Silvers¹⁰ report of four cases cured by using preoperative x-ray therapy, decided to try this method and used it in four successive cases. All died from metastases and Gross then abandoned this method, convinced that the best overall results were obtained by immediate surgery, followed by irradiation.

IN OUR OWN experience, all of the five cases treated with preoperative x-ray died; but of the five treated by immediate surgery followed by x-ray, four survived. All nephrectomies but one in this group were translumbar and retroperitoneal; one was transabdominal. There is considerable disagreement among urologists as to the best surgical approach. Gross, who has reported the largest series, advocates transabdominal nephrectomy. Among the most recent approaches which should and no doubt will be applied are the thoraco-abdominal operation advocated by Chute.¹¹ (O'Connor¹² has reported a case of a four-year old male treated by preoperative and postoperative x-ray and transthoracic nephrectomy who is still alive fifty-two months after operation.) The bone-muscle flap operation of Nagamatsu¹³ and the radical nephrectomy of Foley,¹⁴ in which all of the perirenal tissue is removed *en masse* with the kidney, may be used. Certainly the principles of immediate surgery, early ligation of the pedicle and complete and radical removal of all surrounding tissue are basic.

The advisability of postoperative irradiation is less controversial than that of preoperative irradiation. If the tumor has extended locally beyond the capsule, or if metastases are present or develop, postoperative treatment should be

given. Nesbitt and Adams¹⁵ state that three of their eight living patients in a group of sixteen owe their survival to radiation therapy. They report a patient with a pathologically proved inoperable Wilms' tumor, treated by roentgen therapy alone, who has survived more than ten years. The present policy adopted by the Columbia-Presbyterian Medical Center in New York is that of immediate surgical removal of the tumor followed by routine postoperative irradiation of the tumor bed. Metastases are treated as they occur. The technic usually employed is as follows: 200 KV, filtration 0.5 mm. copper plus 1 mm. aluminum, HVL of 0.9 mm. of copper with a target skin distance of 50 cm. Anterior and posterior fields are used and 100 to 200 roentgens in air are given to a single portal daily, depending on the size of the field. The total air dose to each field is carried to a total of 2400 to 3000 roentgens which will deliver a tumor dose of between 3000 to 4000 roentgens at the bed of the renal pedicle.

Caution and experience are necessary to avoid overirradiation of a small patient with a disseminated tumor. The remaining kidney should be carefully shielded to avoid the possibility of a radiation nephritis. Campbell¹⁶ has seen three cases of radiation nephritis, two of which were fatal. Radiation pneumonitis may also occur during the treatment of pulmonary metastasis, especially if more than one course of treatment to the lung is necessary. Once a pulmonary or brain metastasis occurs the prognosis is usually hopeless.

PROGNOSIS

CERTAINLY the outlook for children with embryonal renal tumors is more hopeful than it was several decades ago, particularly in the group below twelve months of age. Early recognition and immediate surgery will probably affect the prognosis. In all of our survivals, the time lapse between first seeing the patient and the removal of the kidney was less than one month. In the deaths, in all cases but two, the lapse of time was over one month, in one case five months. In one of the deaths with

an interval of less than one month, there was evidence of tumor spread. In all cases where it was over one month, there was evidence of tumor spread at the time of operation. If patients survive operation for eighteen months following the nephrectomy without evidence of local spread or metastasis, cure is likely.

SUMMARY

MIXED embryonal tumors in children are easily recognized. The diagnosis can usually be made by the discovery of an abdominal mass and pyelography. Early recognition, immediate surgery and postoperative irradiation in our hands has proved the best method of treatment.

144 South Harrison Street *

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Spontaneous Pneumothorax

Spontaneous pneumothorax is defined by Rapport, and associates¹ as an entity resulting from bronchial tree-pleural space communication not established by direct laceration of lung tissue. In a review of their cases etiology was classified under the following groups: 1) Structural cystic lung diseases, 2) inflammation, 3) emphysema, 4) trauma and 5) idiopathic. In many, if not all cases of spontaneous pneumothorax, the condition is caused by rupture of subpleural blebs or bullae which may have been congenital or the result of local changes produced by obstructive emphysema, pneumonia, cystic bronchiectasis or tuberculosis. Only 6 per cent of the cases were caused by the last named infection. A history of indirect

trauma preceding the pneumothorax is rare.

Spontaneous pneumothorax with less than 25 per cent collapse should be treated conservatively. The patient should be closely watched for progressive collapse. If greater than 25 per cent, active surgical intervention is recommended.

Insertion of a catheter into the pleural cavity with a water-seal drainage may be easily done with local anesthesia. This provides more rapid re-expansion of the lung, early relief of symptoms, prevention of complications and more rapid cure.

In progressive hemopneumothorax, persistent bronchopleural fistula and multiple recurrences, thoracotomy and definitive surgery such as resection of blebs, segments or lobes are indicated.

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DABNEY MOON, M.D.
HENRY J. MINEUR, M.D.
GUY R. HOPPER, M.D.
SAMUEL H. SCHWARTZ, M.D.

Plainfield

Ballistocardiographic Studies of Ethaverine as a Coronary Vasodilator*

Preliminary Report

Ballistocardiographic and clinical evidence is presented in this preliminary study to suggest that Ethaverine® may be of value in the treatment of coronary insufficiency.

THIS paper presents the results of a study of Ethaverine®† as a coronary vasodilator in twelve patients. Six patients showed ballistocardiographic improvement, four showed less reliable subjective improvement, and no benefit was observed in the remaining two.

Ballistocardiograms were interpreted as recommended by Dock,¹ using the four grades of Brown.² Under this method of classification grade 4 (maximal abnormality) indicates totally abnormal complexes of low amplitude under basal conditions. Grade 3 (marked abnormality) includes cases which, at rest or after exercise, show notched J waves or low amplitude irregular I-J waves, usually becoming unidentifiable in expiration. Grades 1 and 2 (definite abnormality) show unusual respiratory variations at rest or after exercise, with good amplitude during inspiration.

Ethaverine® (6,7 diethoxy-1-[3', 4' diethoxybenzyl]-isoquinoline) was first used in Europe as a gastro-intestinal antispasmodic and more recently has been found to have a coronary vasodilating action. Compared to papaverine (to which it is similar in structure with ethoxyl groups replacing methoxyl groups), it has as

great a peak in coronary vasodilatation, but with later and more prolonged action, so that there is about twice the physiologic effect; furthermore, it is one-quarter to one-sixth as toxic as papaverine; even 200 to 250 mgm. in a single dose do not produce any unusual reaction.³ Goldstein⁴ has reported its use in over 100 patients in dosages of 40 to 80 milligrams four times daily with no untoward side-effects except nausea in one patient; there is no evidence of addiction.⁵

RESULTS

THE dosage of Ethaverine® in each of the twelve cases was 25 milligrams four times daily. Ballistocardiograms were taken before the drug was started and patients followed at intervals with ballistocardiograms or changes in symptoms.

In six patients there was ballistocardiographic improvement, one of which was only temporary; in four there was subjective improvement, in one no change, and in the twelfth

* From the Heart Clinic, Muhlenberg Hospital, Plainfield, N. J.

† The National Drug Company, Philadelphia, Pa., supplied Ethaverine for this study.

patient the drug was discontinued because of "pounding" in the head. These patients are to be continued under observation and any further progress noted.

A tabulation of the twelve cases is presented in Table 1.

evident. While the material presented herein is far from conclusive there is evidence that Ethaverine® may be of value in improving coronary circulation. Further studies of these and other cases are indicated.

SUMMARY

WITH the increasing incidence of coronary artery disease the importance of finding an effective coronary artery vasodilator is self-

THE pharmacology of Ethaverine® and results of preliminary studies of its use as a coronary vasodilator, utilizing the ballistocardiogram in certain cases, have been presented.

TABLE 1. RESULTS WITH ETHAVERINE®

Case	Age	Sex	Diagnosis and Blood Pressure	Symptoms	Ballistocardiogram before Ethaverine®	Subsequent Ballistocardiographic Findings	Remarks
I. Ballistocardiographic Improvement:							
F.B.	53	M	Arteriosclerotic heart disease; coronary insufficiency; normotensive	Substernal pain on excitement	Grade 2	Grade 1 (borderline normal)	Subjectively much improved
E.A.	38	F	Hypertension; 160/100	Dyspnea; ankle edema	Grade 3	Grade 2	Definite ballistocardiographic improvement, persisting while on placebo
E.J.	65	M	Arteriosclerotic heart disease; coronary sclerosis; myocardial infarction (12/30/51), healed; normotensive	Fatigue	Grade 2	Grade 2 (improved)	Subjectively same
C.T.	36	F	Rheumatic heart disease, mitral insufficiency and stenosis; normotensive	Chest pain on exertion; occasional palpitation	Grade 1	Normal	Subjectively improved
W.W.	74	M	Arteriosclerotic heart disease; hypertension; diabetes mellitus; 170/90	Dyspnea; ankle edema (intermittent)	Grade 2	Grade 1; normal for age	Able to return to work
R.B.	52	F	Arteriosclerotic heart disease; hypertension; 190/140	Lethargy; exertional dyspnea	Grade 2 deep, slurred K	Marked improvement, normal for age; later partial relapse	Initial ballistocardiographic improvement; not fully maintained
II. Subjective Improvement Only:							
H.R.	68	M	Arteriosclerotic heart disease; auricular fibrillation, intermittent; normotensive	"Weakness about heart" on exertion; occasional palpitation	Grade 1 (borderline normal)		Subjectively improved
M.R.	71	F	Arteriosclerotic heart disease; right bundle branch block; hypertension; 230/120 - 158/102	"High blood pressure"; weakness	Grade 3		Subjectively improved

Case	Age	Sex	Diagnosis and Blood Pressure	Symptoms	Ballistocardiogram before Ethaverine®	Subsequent Ballistocardiographic Findings	Remarks
L.W.	61	F	Arteriosclerotic heart disease; hypertension 250/110 - 210/108	Occasional smothering feeling in chest	Grade 1	No change	Subjectively felt better; on maintenance digitalis throughout
A.S.	65	F	Arteriosclerotic heart disease; hypertension; 240/100 - 164/80	Headaches; attacks of vertigo	Grade 2	No change	Subjectively felt better

III. Cases Showing No Improvement:

G.G.	64	F	Arteriosclerotic heart disease; hypertension 210/110 - 180/100	Smothering sensation in chest; mild dyspnea	Grade 2	Grade 2; no change; later Grade 3	Ballistocardiogram worse; chest pain attributed by patient to Ethaverine®
E.L.	38	F	Rheumatic heart disease; mitral insufficiency and stenosis; thyroidectomy 1947 for hyperthyroidism; cerebral thrombosis, 1952; 180/100	Occasional dyspnea on exertion	Grade 3	Grade 3	Ballistocardiogram unchanged; Ethaverine® discontinued because of "pounding in head"

706 Park Avenue

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Arthritis Deaths

Contrary to the commonly held belief that rheumatoid arthritis is an illness conducive to longevity, the studies of Cobb, *et al.*¹ indicate that the life expectancy of such patients is less than the average. Utilizing life-table methods borrowed from actuaries this group found that hospitalized patients with rheumatoid arthritis have a higher mortality than that of the general population. This was found to be due to the fact that younger people, especially males, succumbed more rapidly than expected. In

patients over fifty the life expectancy was not noticeably changed.

In patients with rheumatoid arthritis the causes of death differ from those in the population at large. The most frequent causes of death were valvular heart disease, infections of all types, kidney disease and pulmonary embolism. Infrequent causes of death were accidental deaths, hypertensive heart disease and myocardial infarction.

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HENRY A. DAVIDSON, M.D.†
Arlington, Va.

The Statistician's Place in Medical Research

Investigations are frequently handicapped by unfamiliarity with statistics. The importance of obtaining a statistician's aid in clinical research is emphasized.

You have tried a new drug and you are gratified. You have prepared a neat table of results. Headache relieved in 42.5 per cent, and headache much improved (whatever *that* means) in 17.8 per cent. And umpteen per cent of the patients showed less vertigo. Not bad. You publish the article, and a dozen readers ask for reprints, which leaves only 488 reprints in your cellar at home. The program chairman of the Teratoma County Medical Society asks you to present this subject at the next meeting. You begin to rehearse an acceptance speech for the Pulitzer Prize.

Then another author comes out with a report. He used your new drug and the results were the same in the treated group as in the control series. No one else duplicates your results. Somebody points out that your percentages of improvements have not been shown to be statistically greater than could be accounted for by chance alone. Within a year it's all forgotten, except that you wish you had never given the idea the immortality it now has, forever linked to your name in *Index Medicus*.

This is a common story. Leaf through some ten-year old issues of this or any other medical journal. Where are the drugs so enthusiastically reported then? Most of them are in limbo. And most of their early author-promoters forget to list these papers in their own bibliographies.

FIGURES CAN LIE

THE premature optimism which fizzled out so weakly was, in some instances, due to failure to weigh the psychic effects of a new procedure or a new drug. But more often it was due to amateur use of statistics: not to errors in arithmetic, nor to inaccurate recording, but rather to the author's failure to allow for "chance" variations. Most physicians are too busy to learn the technic of statistical validation; and, unhappily, too unsophisticated in statistics to realize the necessity of such validation.

There is one way of preventing this kind of boner—but many doctors won't take it. That is to have a professional statistician analyze and validate the figures. Many practitioners never think of consulting a statistician. Many think of it but don't know where to find one. And others balk at asking for statistical help on the naive theory that they themselves can add figures just as well as any Ph.D. in mathematics.

PERCENTAGES ARE NOT WHAT THEY SEEM

CLINICAL research is usually aimed at answering questions such as: is this procedure (or drug) really helpful? Is that factor a major determinant in causing these symptoms? Actually the pay-off questions are, and must be:

† Formerly editor of this JOURNAL.

how much of the favorable result is due to chance, how much to extraneous factors and how much to the drug or procedure under investigation?

Suppose you have studied 50 cases of subacute omphalitis. You find that 41 of these had excessive bratelline in the urine. That amounts to 82 per cent. What does this mean? Is the ratio high enough to indicate a significant relationship between the excess bratelline and the subacute omphalitis? What other factors cause bratellinuria? And the key question: how many cases of excessive bratelline would you find in an unselected group just by chance?

This is, in a sense, the root problem of modern statistics: determining the extent to which "chance" causes a result. And the answer is developed by rigorous mathematical methods, not by tossing coins or communing with ouija boards. And not by "common sense" either.

THE CHANCES ON CHANCE

SUPPOSE the mortality rate in epizootic agrypnia is usually 15 per cent. Patients treated by your method show a 9 per cent mortality. This difference may be meaningful; or may be due to chance. Common sense does not give the answer. Mathematical analysis does.

When results are expressed in numbers, a simple comparison will not give a valid conclusion. If your new drug reduces the disability period from an 8 day to a 5 day average, it is necessary to validate the difference before concluding that the difference was due to the drug. It might have been due to chance. Here's where the statistician comes in. He needs more than a few raw numbers however. He wants to know the size of the sample, and the number of cases in each group; the number with 2 day disabilities, the number with 3 day disabilities, the number with 4 day disabilities and so on. His answer might then be: "There is only one possibility in 270,000 that this difference was due to chance." In basic English, this means that the difference is really significant, and your drug really does help. But if he finds that there is a one to three possibility

that chance alone would have accounted for the difference, the experienced investigator does not rush into print with any dogmatic conclusions. But you cannot, by common sense, tell whether the difference is due to chance. For that you need a specific and somewhat specialized statistical technic.

CALL THE STATISTICIAN EARLY

A STATISTICIAN, like an obstetrician, should be called in *before* the labor is underway. When consulted, the statistician may ask for some data the doctor never thought of collecting. And by this time it may be too late. One resident in cardiology, for example, carefully collected figures on the hospitalization frequency for various vocational groups. He wanted to find out whether heart disease in certain occupational groups led to hospital admission more often than in others. A year later he took the data to a statistician for validation. The latter's first question was: what were the ages of your various groups? Nowhere in his dozen summary tables was there any listing by age brackets. It would have taken months of digging through individual hospital records to have reconstructed age bracket tables. The entire project was handicapped, its results seriously questioned, because no one could say for sure whether the variations between the vocational groups were not actually due to differences in age rather than differences in occupation. The moral: call the statistician while the project is still in the blue-print stage; or at the latest, after the clinical work has been done but while records are still open and patients still available.

A statistician can help set standards for "controls" and for "matched pairs." In some projects, for example, a placebo is given to one group of subjects and the drug under test to another group. No one but the investigator knows which is which. Here the controls are intended to neutralize the "psychic" factor in the improvement of the patients.

In other types of projects, extraneous factors are neutralized by matching each subject with a corresponding "control" on a one to one basis. A new type of hernia repair is done

on ten patients. Results are good. But maybe the subjects differed from the controls (who received the old-fashioned operation) in color, age, sex or recency of hernia. The ideal would be to match the groups so perfectly that they would differ only in the nature of the operation. Then a valid difference in results could be honestly credited to the new operation. This ideal of perfect, paired matching is usually not achieved. But the statistician—if consulted early—can usually help in determining criteria for approaching this ideal; and in estimating how much allowance must be made for variations from perfect matching.

TO ERR IS HUMAN

STATISTICIANS have their own jargon. They lightly toss off chi squares and linear regressions. Kurtosis is no more mysterious to a statistician than kyphosis is to an orthopedist. Among themselves they happily talk of sigmas, rhos and phis—all Greek to the doctor but capable of producing hypertension among biometricians.¹ The clinician need no more worry about this jargon than the patient needs to know the difference between an eosinophile and a basophile.

One statistician's word has to be understood though: don't be insulted when he speaks of

"errors" in your work. He does not mean that you have blundered. The statistician uses "error" in its original Latin sense of "wandering"; that is, of fluctuations from a central point.

Where do you find a statistician? Almost any institution doing substantial research has a statistician or two housed in the attic or in the basement. State health departments, state hospital systems and large industrial corporations commonly have statisticians on their staffs. Some work for investment brokers. Almost any well-trained psychologist can handle statistical tools well enough to do the validating that a doctor might need on a clinical research project. Most college teachers of mathematics can handle statistics competently or can refer the inquirer to a statistician. And the American Statistical Association² will supply a list of its members in the vicinity.

Sometimes a statistician serves only to blaze a trail from a doubtful assumption to a foregone conclusion.³ Even if he does no more than that, he can help the clinician by providing a solid mathematical validation for conclusions that might otherwise be challenged.

1. A biometrician is a statistician after he has had a one-grade Civil Service promotion.

2. Address: 1108 Sixteenth Street, N. W., Washington 6, D. C.

3. Borrowed without permission from Emil Frankel, Ph.D., Director, Statistics and Research, Department of Institutions and Agencies, State of New Jersey.

4042 North 25 Street

Aureomycin Dressings

Aureomycin® dressings have been found valuable in the treatment of surface wounds such as burns, skin graft donor sites, abrasions, excoriations, avulsions, and ulcers. In a study of 77 cases comprising 65 burns and 12 ulcers, Tamerin, *et al.*¹ have shown that Aureomycin® dressings successfully suppress the growth of

pathogenic organisms. In this group of cases over 2,000 Aureomycin® dressings were used with no untoward reactions and no interference with wound healing. Wounds were found to heal with unusual rapidity and skin graft donor sites healed quickly. This dressing provides a convenient, readily available dressing offering a protection against infection and facilitating the healing of surface wounds.

1. Tamerin, J. A., Metzger, W. I., and Wright, L. T.: Aureomycin Dressings. *Am. J. Surg.*, September, 1953.

DAVID B. MILLER, M.D.
RALPH J. BELFORD, M.D.
Princeton

Primary Torsion of the Omentum*

Torsion of the omentum with gangrene produces an ill-defined clinical picture, but responds readily to surgery. A typical case is reported.

TORSION of the omentum is an entity not usually diagnosed preoperatively but often successfully differentiated and treated at laparotomy. As suggested by Leitner, Jordan, Spinner and Reese,¹ the condition may be primary or secondary; the former occurs without definite cause, the latter always involves other intra-abdominal organs to which the free end of the omentum becomes attached. Consequently, the sequence of events following secondary attachment is rather easily explained, while the operating mechanism in primary torsion is not always apparent.

Leitner, *et al.*,¹ describe predisposing causes of primary torsion, e.g. anatomic variations, obesity, epiploitis, unusual arrangement of blood vessels, tumors or cysts, and exciting causes such as trauma, hyperperistalsis and vascular changes in the omentum. To the approximately 100 cases of primary torsion reported in the literature, we should like to add a rather unusual case in a child, in which the exciting cause was apparently external trauma in the form of a common childhood pastime—rolling downhill.

CASE REPORT

C. R., a 6-year old female, was in excellent health until May 9, 1952. On that date she complained of lethargy, slight anorexia and a feeling of vague abdominal discomfort. The following morning she was better and felt well enough to attend a birthday party, where she was observed on several occasions rolling over and over, down a 10-foot grassy slope, in company with other children. That evening

she complained of moderate low abdominal pain, and refused supper. The following morning the pain was intensified, she vomited once, and her pediatrician admitted her to the hospital with a tentative diagnosis of acute appendicitis.

Upon admission, the temperature was 99.6°F, the white cell count was 14,000 with 75% polymorphonuclears, 20% lymphocytes, 4% monocytes, and 1% eosinophiles. The abdomen was soft, with very slight guarding over the right rectus muscle. No rebound tenderness was present and peristalsis was active. Rectal examination was normal. It was felt that the most probable diagnosis was mesenteric adenitis or low-grade appendicitis. An enema was given, without change in symptoms, and the blood count repeated in four hours. At that time, the white cell count was 23,550 with 88% polymorphonuclears and 10% lymphocytes. The abdominal picture had not changed and still did not strongly suggest acute appendicitis, but operation was advised in view of the rapidly rising white blood count.

Through a small McBurney incision the appendix was exposed, but other than slight periappendiceal injection, it did not appear to be inflamed. There was slight similar injection of the cecum and terminal ileum. The tip of the omentum was then visualized at the upper part of the field and was obviously gangrenous. The omentum was drawn into the incision and there appeared to be a torsion of the terminal six or seven inches, with several twists proximal to the involved portion. Resection was accomplished without difficulty. Search for a Meckel's diverticulum was unrewarding. No hernia sacs were present. The operation was terminated with appendectomy and recovery was without incidence.

Pathology: A thin, flat piece of light yellow fat and delicate membranous tissue, 24 cm. in length. One half fanned out to show the structure of a thin omentum, the other half was thick (6 mm.), folded longitudinally and bright red. Between these portions, the structure was repeatedly twisted into a cord, 3 centimeters long and only 3 millimeters wide at its narrowest portion. The appendix showed hyperemia and hemorrhage. The lumen contained cross sections of *Enterobius vermicularis*.

DISCUSSION

IT WAS the original feeling of the pathologist that an inflamed appendix may have been the point of attachment of the omentum, which then became secondarily freed. In this case, however, the appendix was somewhat retrocecal and exhibited no pathologic changes sufficient to suggest that the omentum had been attached to it. It seemed more likely that the initial symptoms may have been due to beginning torsion of undetermined cause, which were then promoted by the external violence of rolling over and over. There was obviously an unknown predisposing factor, for the incidence of torsion of the omentum among frolicsome children is not alarming.

The symptoms in this case, as is usual, were not striking nor diagnostic. They were merely suggestive of a continuing intra-abdominal process, vague in nature.

SUMMARY

A REPORT of primary torsion of the omentum occurring in a 6-year old female is presented, with a suggestion as to etiology. It serves as a reminder that such a condition exists and should be considered when no obvious pathology is present at operation in preoperatively incriminated appendix, Meckel's diverticulum, mesenteric nodes, gallbladder, peptic ulcer, etc.

90 Nassau Street

REFERENCE

1. Leitner, M. J., Jordan, C. G., Spinner, M. H. and Reese, E. C.: Torsion, Infarction and Hemorrhage of the Omentum as a Cause of Acute Abdominal Distress. *Ann. Surg.* 135:103, January, 1952.

Antibiotic Therapy in Infectious Mononucleosis

In a controlled series of seventy-eight patients with infectious mononucleosis the failure of antibiotic treatment to alter the course of the disease was demonstrated by Walker.*

Seventy-eight patients admitted to the Uni-

versity Hospital of Cleveland and the Contagious Division of The Cleveland City Hospital between January 1, 1948 and June 1, 1951 were studied. Patients were treated with Aureomycin,[®] chloramphenicol, and penicillin. In spite of previous enthusiastic reports none of these agents was demonstrated to influence the course of the disease.

* Walker, S. H.: The Failure of Antibiotic Therapy in Infectious Mononucleosis. *Am. J. M. Sc.*, July, 1953.

EDWIN A. SEIDMAN, M.D.
ABDOL H. ISLAMI, M.D.
RENATO R. ESPINOSA, M.D.*
Newark

Presacral Pneumography*

The value and limitations of presacral pneumography are outlined, with representative case presentations.

PRESACRAL pneumography as a method of visualizing the retroperitoneal spaces affords valuable means of determining renal, adrenal and retroperitoneal pathology. The topographic and morphologic outlines of the kidneys, adrenals and retroperitoneal structures can be delineated accurately, and pathologic variations are often demonstrated when other methods are equivocal.

In 1947 Rivas¹ first described a method by which a diffuse emphysema could be produced throughout the cellular tissue of the whole body by means of a single puncture into the presacral areolar tissue. With the introduction of pure oxygen he was able to delineate simultaneously the retroperitoneal organs bilaterally and occasionally to demonstrate the spleen, liver and diaphragm.

Mosca² utilized retroperitoneal emphysema as a procedure in over 200 cases in which standard methods failed to provide conclusive diagnostic information. He pointed out that roentgenologic investigation of intra-abdominal tumors could be done by retroperitoneal emphysema.

In 1951 Blackwood³ described a technic which he called presacral perirenal pneumography. This differed from the method of Rivas in that the site of the needle puncture was placed distal to the tip of the coccyx and the needle was directed parallel to the plane of the sacrococcygeal hollow whereas Rivas placed

the puncture site lateral to the sacrococcygeal articulation. In over 100 urologic cases Duff, Kenyon and Hyman⁴ employed a modification of Rivas' retroperitoneal pneumography in combination with intravenous urography or retrograde pyelography and obtained additional information.

This paper emphasizes the ease and simplicity of performing presacral pneumography, the diagnostic value derived from this procedure and the paucity of untoward reactions attending its use. In our series of 50 cases the original technic of Rivas with slight modification was followed. The test was used in 32 males and 18 females whose ages ranged from four and one-half to seventy-seven years.

TECHNIC

PREPARATION includes shaving of the sacrococcygeal area and buttocks. Castor oil is given at bedtime. Breakfast is withheld. The patient is encouraged to remain ambulatory the morning of the procedure in order to minimize the accumulation of gas in the bowel. One half hour beforehand Demerol®, 100 mg., and sodium phenobarbital, 0.1 Gm., (gr. 1½) are given intramuscularly.

A preliminary flat film of the abdomen is taken. This demonstrates how well the patient

* From the Department of Urology, City Hospital, Newark, New Jersey.

has been prepared and reveals any abnormalities of the bony framework, particularly in the region of the sacrum and coccyx. The patient is placed in a modified genu-pectoral position on the radiographic-cystoscopic table with a pillow under the face and two pillows under the hip.

*A*SEPTIC technic is employed. The skin of the sacrococcygeal area and buttocks is painted with tincture of merthiolate and draped. The lateral border of the sacrococcygeal articulation is identified on either side, and about one centimeter lateral to this point a wheal is made with 3 cc. of 2% procaine solution using a 25 gauge hypodermic needle. The underlying subcutaneous tissue is infiltrated with more procaine. With the glove-covered index finger in the rectum an ordinary 18 or 20 gauge lumbar puncture needle with the obturator in place is introduced into the designated puncture site. The needle is directed and advanced forward, medially and cephalad until the tip of the needle is barely palpable with the index finger in the rectum. At this distance the tip of the needle is considered resting in the presacral cellular tissue. The obturator is removed from the needle, and the presence or absence of blood coming from the needle is ascertained by aspiration. If no blood appears from the needle the position and distance of the needle within the presacral areolar tissue can be fixed by a curved Kelly clamp applied to the needle which holds it snugly against the skin. The glove-covered index finger in the rectum is removed, the glove is discarded and replaced by another sterile one.

The needle is attached to a three-way stopcock. A 50 cc. Luer lock syringe is attached to one limb of the stopcock, and to the other limb is connected rubber tubing to an oxygen tank supplied with a pressure gauge. The amount of oxygen to be injected is calculated on the basis of 15 cc. of oxygen per kilogram of body weight. In some cases, particularly pathologic states, the amount of oxygen injected would be to the point of tolerance of the patient. The oxygen tank is set to a reading of from 1 to 2 liters per minute, and oxygen is introduced fractionally by means of the 50 cc. syringe, the

plunger of which is advanced with a constant and gentle force. Manometric control of the injection pressure is not required. The proper position of the needle can be determined by rectally palpating a bulge at the tip of the needle as oxygen is introduced into the presacral space. The absence of the characteristic bulge or difficulty in advancing the piston of the syringe signifies either that the tip of the needle is lodged in the connective tissue around the rectum or retro-rectal pathology exists. The former is remedied by changing the position of the needle. The entire procedure can be accomplished within ten minutes.

The patient is turned on his back so that the parts to be examined are closer to the cassette, and the head is elevated about 15 degrees in order to facilitate the diffusion of the gas around the retroperitoneal organs in the subdiaphragmatic regions. The rise of the oxygen is usually indicated by tympany on percussion of either flank. A 14 x 17 inch film is centered higher than in the usual "K.U.B." position in order to include the entire region of the adrenals and kidneys. The KVP is reduced by five to ten in order to obtain better contrast between the retroperitoneal organs and the oxygen. If the initial film demonstrates adequate distribution of the gas, oblique and lateral films are taken. When added information is sought, either intravenous urography, retrograde pyelography or, rarely, arteriography follows. This combined procedure produces a well-formed, almost three-dimensional image of the kidneys, adrenals and surrounding organs in the retroperitoneal space and enables the interpreter to correlate intrarenal and extrarenal architecture. Occasionally delayed films are taken at suitable intervals, and rarely films are necessary in the upright position in order to delineate the regions of the upper poles of the kidneys and adrenals.

SIDE EFFECTS

*T*HE most frequent complaint of patients who underwent presacral pneumography in this series was soreness of the throat as a result of infiltration of oxygen into the loose areolar cervical tissue. This discomfort usually disappeared in two to three days. In few cases

crepitation in the supraclavicular areas was palpable. Slight difficulty in breathing on both inspiration and expiration just prior to exposure of the films was present in about one half the patients. Chest x-rays taken in some of these patients complaining of dyspnea disclosed mediastinal diffusion of the gas. The majority of patients presented the symptoms of a sensation of fullness and slight discomfort in the epigastrium and flanks during the introduction of the gas and for several hours thereafter. Swelling of the scrotum and the vulva was occasionally observed and disappeared within four to six hours.

Systemic reactions were not encountered. There was no significant change in the blood pressure, pulse or respiration during or following the procedure.

Almost all of the patients had slight discomfort at the site of the needle puncture when the effect of the procaine solution wore off. In this series of cases penetration of the rectum or a blood vessel did not occur. No instance of serious or prolonged untoward effects occurred.



Figure 1. Retrograde pyelogram discloses indefinite calyceal deformity for diagnosis of renal tumor.

No. 1. H. S., a 70-year old white male, was referred for urologic study because of x-ray evidence of metastatic lesions involving the left hip and right shoulder. There were no urinary symptoms. The retrograde pyelogram of November 1952, showed inconclusive evidence of structural abnormality. A repeat retrograde pyelogram in January 1953, (Figure 1) disclosed findings similar to those seen in the initial pyelogram. The retrograde pyelogram supplemented by presacral pneumography (Figure 2) revealed a very large tumor of the upper pole of the left kidney. Nephrectomy disclosed hypernephroma.

No. 2. C. D., a 45-year old white female, presented signs and symptoms typical of Cushing's syndrome. Presacral pneumography revealed a large left suprarenal mass (Figure 3) which was not identified by excretory urography. Preoperative diagnosis was adrenal tumor. Operation disclosed a retroperitoneal lipoma in the region of the left adrenal gland. Bilateral sub-total adrenalectomy was also performed. The patient's symptoms of hyperadrenocorticism regressed following operation.

No. 3. A. S., a 67-year old female, gave a history of persistent dull pain in the left flank. Examination disclosed an elderly female in distress. The blood pressure was 164/96. Large nodular masses were palpable in each flank. Retrograde pyelography revealed highly suggestive evidence of polycystic



Figure 2. Retrograde pyelogram of same case as in Figure 1 supplemented with presacral pneumography discloses definite enlargement of the upper pole of left kidney. Operation revealed hypernephroma.



Figure 3. Pneumography identifies a large tumor mass above the left kidney. Surgical exploration revealed a retroperitoneal mass.



Figure 5. Presacral pneumography illustrates the limited diffusion of oxygen around the upper and lower poles and lateral border of the right kidney as a result of perinephritis, proved at operation.



Figure 4. Presacral pneumography demonstrates the markedly enlarged renal outlines of bilateral polycystic disease not demonstrated by conventional means in this case.

disease but the renal outlines were not demonstrated. Presacral pneumography clearly delineated the extremely large size of the kidneys (Figure 4).

No. 4. B. N., a 37-year old female, had previous hospital admissions for ureterolithotomy, suprapubic cystolithotomy and for metabolic studies related to calareous disease of the urinary tract. On her last admission to the hospital on January 16, 1953, she had severe right lumbar pain accompanied by chills, fever and leucocytosis. Marked right lumbar tenderness was present. X-ray studies disclosed multiple small calculi in the regions of both kidneys, with more involvement on the right. There was scoliosis of the lumbar vertebrae with convexity toward the right. The psoas muscle margin was not outlined. Presacral pneumography clearly demonstrated the outline of the left kidney and showed an absence of diffusion around the lateral border of the right kidney to provide evidence of perinephritic abscess (Figure 5). Operation disclosed no perinephritic suppuration but revealed dense and thickened fibrous adhesions around the anterolateral surface of the right kidney which was studded with cortical abscesses.

ALTHOUGH few children were included in this series there would appear to be no significant variations in the performance of presacral pneumography in children except for the necessity of using general anesthesia and a proportionate decrease in the amount of oxygen injected into the retroperitoneum. It is particularly noteworthy that patients with, as well as without, debilitating physical conditions stand presacral pneumography with little discomfort and sequelae. The simplicity and safety of the procedure are impressive.

The practical diagnostic application of presacral pneumography is most useful when conventional diagnostic measures fail to suffice in such conditions as kidney tumor or cyst, hydronephrosis with a large extrarenal pelvis, congenital renal anomalies, perinephritic pathology especially perirenal suppuration, extrarenal retroperitoneal masses and adrenal tumors. It is of great significance that a space-occupying lesion within the renal parenchyma may exist without appreciable pyelographic deformity. In such cases pneumography delineates the renal outline to provide unequivocal identification of a renal mass. Presacral pneumography and the simultaneous use of intravenous urography or retrograde pyelography will clearly demonstrate the thickness of renal parenchyma between calyces and renal capsule. The combined procedure of pneumography and urography is indispensable for conclusive diagnostic evidence in renal disease and is valuable in the presence of extrarenal retroperitoneal pathology. It also affords added information as to operability, surgical approach and management in each case.

In this series the most important application of the procedure was in the recognition of the presence or absence of renal tumor and perinephritic involvement, particularly perinephritic abscess. No roentgenographic criterion establishes the diagnosis of perinephritic abscess. Pneumography, however, does provide a highly

significant finding in the presence of perinephritic involvement. Although perirenal air insufflation was suggested in the past by Carrelli, this procedure found limited application in the presence of perinephritic abscess since the danger of air embolism and the spread of infection was feared. The absence of, or limited diffusion of oxygen around the affected kidney and obliteration of the psoas muscle margin is vividly demonstrated in the presence of perinephritic involvement.

Interpretations of retroperitoneal pneumography show strict limitations. It has been observed in this series that patients with a history of inflammatory intra-abdominal disease or abdominal surgery almost invariably showed on pneumography insufficient or absent diffusion of gas in the retroperitoneal space, particularly around the kidneys and adrenals. Inflammatory infiltration between the posterior parietal peritoneum and the retroperitoneal space and structures probably explains the limited distribution of the gas. Attempts to demonstrate intra-abdominal masses in this series produced results which were frequently inconsistent with the pathologic findings at operation. Only in a small percentage was visualization of the normal adrenal gland entirely satisfactory.

SUMMARY

PRESACRAL pneumography is a simple and safe diagnostic procedure which is attended with minimal side effects and affords valuable supplementary information in the diagnosis of retroperitoneal disease entities.

In contrast to previous reports presacral pneumography afforded very little or no aid in the diagnosis of intraperitoneal tumors in this series.

Pneumography may provide unequivocal evidence of renal tumor in the absence of pyelographic abnormality.

The added diagnostic value of presacral pneumography in cases of perinephritic involvement is emphasized.

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3. Blackwood, J.: Presacral Perirenal Pneumography. *Brit. J. Surg.* 39:111, September, 1951.
4. Duff, J., Kenyon, H. R. and Hyman, R. M.: Retroperitoneal Pneumography with Pyelography: A Preliminary Report. *New York J. Med.* 52:1790, July, 1952.

Pulsus Alternans

Attention has recently been called to the clinical significance of a simple, yet often overlooked, physical finding, pulsus alternans. White¹ points out that because of cardiologists' preoccupation with electrocardiography and other mechanical means of studying the heart, attention has been diverted from this easily detected sign of left ventricular weakness.

Alternation of the pulse is defined as a regular variation of the fullness and pressure of alternate strokes during the regular beating of the heart. The difference in systolic blood pressure varies from 1 to 10 or 15 millimeters of mercury during such alternation. Pulsus alternans may last for hours or days, or exist for but a few minutes. It may also occur for only a few seconds after a premature beat.

A simple method for its detection consists of inflating the sphygmomanometer cuff to the systolic level while the patient holds his breath. The examiner listens carefully for a halving

of the sounds of the pulse beat, or watches the mercury column for halving of the rate, or feels every other pulse beat drop out at the wrist. Other, less simple methods, including recording devices such as the ballistocardiogram may be used.

Pulsus alternans occurs particularly where there is considerable strain on the left ventricle, as in severe hypertension, aortic stenosis or regurgitation, or myocardial infarction, old or new. It is significant because it is one of the useful signs of left ventricular weakness and may appear earlier than other evidence, viz., diastolic gallop rhythm, increasing accentuation of the second pulmonic sound, or dyspnea on effort or paroxysmally at night. When found, pulsus alternans calls for the same treatment as congestive failure of any origin—restriction of activity, digitalization and limitation of the dietary salt intake.

Alternation of the pulse occurring during an attack of paroxysmal tachycardia is a sign of temporary fatigue, and is not of importance prognostically. It is only when it occurs during ordinary heart rates of 60 to 100 that it becomes a significant finding.

1. White, P. D.: Alternation of the Pulse—Still a Common and Important Clinical Condition. *Modern Concepts of Cardiovascular Disease*, 22: May, 1953.

Trustees' Meeting

July 26, 1953

(Minutes approved October 25, 1953)

A REGULAR meeting of the Board of Trustees was held on Sunday, July 26, 1953, at the Executive Offices, Trenton. The following is a summary of the principal actions taken by the Board at this meeting:

In response to a request from the American Medical Association that the State Society send a representative to the Biennial Conference on Health Problems and Education, held in Highland Park, Illinois, in October, 1953, the Board designated Dr. Joseph R. Jehl, Chairman of the Advisory Committee on School Health as the Society's official representative.

A motion was unanimously adopted dismissing, with thanks, the Advisory Committee on Pharmaceutical Problems and authorizing the establishment of a Medical-Pharmaceutical Liaison Committee.

It was reported to the Board that no change has been made in the chairmanship of the Section on Urology for several years, and it was further pointed out that adopted policy requires that all sections hold business meetings during the annual meetings for the purpose of electing new officers. Accordingly, the Board adopted a motion instructing the officers of the Section on Urology be notified of the proper procedure.

THE trustees empowered the president to name the chairman and other members of the Emergency Medical Service Civil Defense Committee, established by the action of the House of Delegates.

Approval was given to the request of the chairman of the Section on Heart Diseases that the section be hereafter known as "Section on Cardiovascular Diseases."

The Board approved the establishment of a plan, sponsored by the State Commission for the Blind, to set up a glaucoma follow-up service in New Jersey with a full-time person in charge. The chairman of the Advisory Committee on the Conservation of Vision and Hearing reported his committee's approval of the project.

Members of the Board authorized the listing of The Medical Society of New Jersey as a member of the Committee of Patrons for the anniversary meeting of the National Tuberculosis Association.

The Board unanimously adopted a motion establishing a special committee for the study of the problem of the division of surgical fees proposed under Medical-Surgical Plan. The committee was directed to study the matter during the year and then submit recommendations to the trustees.

APPROVAL was given by the Board to a request for permission to increase the advertising rates for the JOURNAL as of January 1, 1954, provided that the chairman of the Publication Committee also approves.

Because of the fact that the 1955 annual meeting of the American Medical Association would follow within two weeks in Atlantic City the 1955 annual meeting of the State Society, and because attempts to secure earlier dates at Haddon Hall had been unsuccessful but that late April dates can be secured from the Ambassador Hotel, the trustees authorized the cancellation of the reservation at Haddon Hall for May, 1955 and the acceptance of reservation at the Hotel Ambassador for April 17-20, 1955, instead.

Announcements • • •

Heart Disease Session

The fifth annual scientific session on heart disease will be presented by the New Jersey Heart Association in the auditorium of the Mutual Benefit Life Insurance Company, 300 Broadway, Newark, on Wednesday, March 17, 1954. Dr. Robert B. Durham of Atlantic City, chairman of the Program Committee, has obtained six outstanding speakers to present various phases of cardiovascular disease. All physicians in the state are cordially invited.

Prize Essay Contest

The Mississippi Valley Medical Society announces its thirteenth annual essay contest for 1954. A cash prize of \$100 will be awarded for the best unpublished essay on any subject of general medical interest, including medical economics and education. Further details may be obtained from the secretary, Harold Swanberg, M.D., Mississippi Valley Medical Society, 209-224 W.C.U. Building, Quincy, Ill.

Multiple Sclerosis Pamphlet

The National Multiple Sclerosis Society has prepared a pamphlet to be read by patients with this disease. Simple illustrations explain the nature of the illness and methods of treatment are described. Copies may be obtained from the Public Inquiries Branch, Public Health Service, Department of Health, Education and Welfare, Washington 25, D. C.

Ophthalmologic Congress

The Pan-American Association of Ophthalmology will hold its third interim Congress in Sao Paulo, Brazil, June 17-21. Scientific sessions will be devoted to recent advances in treatment of eye diseases and prevention of blindness. Simultaneous translations in English, Spanish and Portuguese will be provided.

Concurrently the Eighth Brazilian Congress of Ophthalmology and the Nineteenth International Congress of Oto-Neuro-Ophthalmology will meet in Sao Paulo.

EENT Meeting

The New Jersey Society of Ophthalmology and Otolaryngology will hold its annual meeting at the Hotel Dennis, Atlantic City, March 5-6. Reservations may be made by writing to Mr. Robert W. Phillips at the Hotel Dennis.

Guest speakers will include Drs. Louis H. Clerf and Harold G. Scheie of Philadelphia, Drs. Max Chamlin and Frederick H. Theodore of New York City, Dr. Philip E. Meltzer of Boston, and Dr. John R. Lindsay of Chicago.

Proctology Award

The International Academy of Proctology announces its annual award contest for 1953-54. A prize of \$100 will be given for the best unpublished contribution on proctology. Entries must be submitted by February 1 to the International Academy of Proctology, 43-65 Kissena Blvd., Flushing, N. Y.

Psychiatric Residencies

The United States Civil Service Commission announces an examination for applicants for rotating interns and residents in psychiatry and neurology. These appointments will be made at St. Elizabeth's Hospital, Washington, D.C., starting July 1, 1954. Further information may be obtained from the United States Civil Service Commission, Washington 25, D. C.

Alcoholics Anonymous Meeting

The Fifth Annual International Group of Doctors in Alcoholics Anonymous will meet at the Mayflower Hotel, Akron, Ohio, May 14-16. Further information may be obtained directly from the Mayflower Hotel.

Circulatory Diseases Society

The New York Society for Circulatory Diseases will hold a regular meeting in Room 440, New York Academy of Medicine, February 9 at 8:30 p.m. A panel will discuss the newer anti-hypertensive drugs.

County Society Reports • • •

Atlantic

A regular monthly meeting of the *Medical Society of Atlantic County* was held at the Traymore Hotel, November 13, 1953, Dr. E. Harrison Nickman, presiding.

The guest speaker was Dr. Mitchell I. Rubin, Professor of Pediatrics, University of Buffalo Medical School, whose subject was pediatric problems.

Dr. Diskan spoke briefly of the many current magazine articles which tend to place the medical profession in a poor light before the public. He stated that although these articles are printed solely for sensational effect, and in small print absolve the great majority of physicians, their detrimental effect cannot be ignored. To offset this poor publicity, he suggested the use of a motion picture, entitled "The Doctor" issued by R-K-O, sponsored by the AMA, which may be obtained for \$70, and which should be shown to civic and educational groups. It was moved and seconded that the sum of \$70 be expended from Bulletin profits for the purchase of the film, "The Doctor," for such showings.

Dr. Gleason announced a change in Blue Cross policy known as "Comprehensive Plan." This new plan embodies all the features of the previous policy plus increased benefits as outlined in a folder which was distributed to all the members. The society moved to adopt the comprehensive policy as presented.

LEONARD B. ERBER, M.D.
Reporter

Bergen

The regular monthly meeting of the *Bergen County Medical Society* was held jointly with the Bergen County Pharmaceutical Association, on December 8, 1953, at Bergen Pines Hospital, with the president, Dr. Winton H. Johnson, presiding.

The following were elected to membership:

Associate—Drs. Louis A. Pyle, Jr. and Theodore H. Goldberg; regular—Dr. Joseph F. Videtti; associate to regular—Drs. Carter M. Ballinger, Richard P. Keating, Walter T. Kuhnen, George L. Miller, Richard H. O'Connor and John E. Ross; regular by transfer—Drs. Armin W. Docter, from Madison County (Illinois) and Stanley E. Prentice, from Kings County (New York). Dr. Harriet L. Knox was elected to emeritus membership.

A report on the Bergen Community Blood Bank was submitted by Dr. R. M. Anderson, chairman of the Blood Bank Committee. Dr. Anderson described the purpose of the campaign, emphasizing the \$25,000 goal set by the Committee so that the county society may purchase the site and building where the Bergen Community Blood Bank will be established. Dr. Anderson urged everyone present to send his contribution in without delay.

The guest speaker of the evening, Dr. Morton J. Rodman, Associate Professor of Pharmacology at

Rutgers University College of Pharmacy, spoke on hypotensive agents.

JOHN E. McWHORTER, M.D.
Reporter

Burlington

The *Burlington County Medical Society* convened at the Riverton Country Club for a regular meeting on November 12, 1953 with President Freeman W. Metzger, M.D., in the chair.

The speaker of the evening was Dr. Joseph Hughes, Professor of Psychiatry, Woman's Medical College, Philadelphia. His subject was, "How Well Are You?"

During the business meeting that followed a revised schedule of medical fees as proposed by the Committee on the Revision of Fees was adopted.

WILLIAM F. BETSCH, M.D.
Reporter

Cumberland

Resistant congestive failure was the topic of the scientific program for the December meeting of the *Cumberland County Medical Society*, which was held at the Centerton Inn, Centerton, on December 8, 1953. The speaker was Dr. Louis LaPlace, Assistant Professor of Medicine at Jefferson University Hospital, president, South Philadelphia Heart Society and immediate past president of the American Heart Association. Forty-one members were present with Dr. Kurt M. Hansen presiding.

GEORGE F. RISI, M.D.
Reporter

Gloucester

President Ralph L. Moore, M.D., was in the chair as the *Gloucester County Medical Society* entertained the Cumberland County Society at the Woodbury Country Club, November 19, 1953.

I. S. Raydin, M.D., Professor of Surgery at the University of Pennsylvania, spoke on the subject "Medical Experiences in the Far East."

James G. Kehler, M.D., reporting about the state Public Relations Committee meeting, stated that complete emergency medical coverage was the goal for this year. It was decided that each community should develop its own program.

LOUIS K. COLLINS, M.D.
Reporter

Hudson

Under the chairmanship of Dr. Joseph P. Donnelly, *Hudson County Medical Society* held its regular monthly meeting on November 3, 1953, at Murdoch Hall, Jersey City Medical Center.

A memorial resolution in tribute to the late Dr. Joseph F. Londrigan was presented by Dr. Vincent Butler.

The society approved of a plan for handling

emergency and night calls through the telephone exchanges, to be publicized in the daily press.

The secretary was directed to send the editor of Collier's magazine a letter of vigorous protest concerning the lead article (pertaining to doctors) in its October 30 issue.

The society approved a standardization of fees for house calls.

The society moved to obtain a clarification of its policy directly from the United States Fidelity & Guaranty Co., with regard to renewal of professional liability insurance policies by physicians.

Elected to membership were Drs. Alfred O. Davies, Gerald H. Eurman, Roy A. Morrow, F. Peter Nicholson, John P. Tooman, and Alexander J. Wishbow of Jersey City; Dr. Lawrence J. Giuffra of Nutley; Dr. Ranald MacDonald of North Bergen; and Dr. C. Patrick Petrosino of Hoboken.

HARRY T. ARONOWITZ, M.D.
Reporter

Middlesex

The regular monthly meeting of the *Middlesex County Medical Society* was held at Roosevelt Hospital, Metuchen, N. J., on November 18, 1953. Dr. Carlyle Morris, the president, presided.

The following new members were admitted: by transfer to regular membership: Drs. Georgette Clarke, Perth Amboy, from Nassau County; and Charles Taber, New Brunswick, from Orange County, New York; to regular membership from associate membership: Drs. Eugene L. Childers, Nixon, and John J. Kangos, New Brunswick; to two year period of associate membership, Drs. William H. Errgong, New Brunswick, Italo Falcone, New Brunswick, Harold B. Fein, South River, Samuel Sklar, Highland Park and Thomas L. Steinberg of Nixon.

Theodore B. Bayles, M.D., visiting physician and director of research, Peter Bent Brigham Hospital, Boston, was the guest speaker. His talk was entitled "Modern Management of Rheumatoid Arthritis."

The society approved a change in the date of the annual meeting in December, 1953 to the second Wednesday.

Dr. Charles H. Calvin presented a group of recommendations from the board of trustees, which were adopted by the society.

HAROLD V. CANO, M.D.
Reporter

Morris

The *Morris County Medical Society* held its regular meeting at the Chilcott Laboratories, Morris Plains, on November 19, 1953.

Mr. Richard Nevin, executive officer of The Medical Society of New Jersey, spoke briefly concerning the problems now facing organized medicine in the state. They are:

A new medical school, emergency medical care, and Veterans Administration treatment of an ever growing number of veterans for non-service connected disabilities.

Marty Mann, executive director of the National Committee on Alcoholism, then addressed the society.

The society expressed itself in favor of the projected annual meeting cruise in 1955 and voted to place an advertisement in the telephone classified section listing the phone numbers of the various physicians' exchanges and hospitals in the county.

ALBERT ABRAHAM, M.D.
Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held September 20, 1953 in the form of an installation dinner, introducing our new president, Dr. Floyd Fortuin. Doctor Fortuin acknowledged, reviewing accomplishments of the society in the immediate past and suggesting numerous problems calling for action in the future through increasingly active committees.

A short business session was held, during which the following were elected to active membership: Drs. Edward M. Gillson and Joseph S. Krakauer, Paterson; Joseph F. Moriarty and Wilbert Sachs, Passaic; Nicholas B. Salistean, Clifton. Elected to associate membership were Drs. Sigurd E. Johnsen, Passaic; Monroe E. Neuman, Richard A. Raffman, and Frank Scillieri, Paterson. Dr. Henry D. Janowitz, Paterson, was elected to courtesy membership.

Dr. Henry H. Kessler gave an address entitled, "The European Image of America."

The regular monthly meeting of the *Passaic County Medical Society* was held on October 20, 1953, at the Medical Society Building. Dr. Floyd Fortuin, the president, presided.

Dr. Archibald Fishberg, Fairlawn, was elected to active membership. Dr. Louis J. Spizziri, Paterson, was elected to associate membership.

Dr. Graham, the treasurer, announced that the dues for the year 1954 would be divided as follows: building maintenance—\$12.00; Physicians Relief Fund \$1.00; county society administration — \$20.00; state society—\$25.00; total—\$58.00.

Dr. Fortuin announced that the Grievance Committee would be asked to recommend disciplinary action for repeated offenders. He also asked that society members give continued support to the principles of voluntary health insurance by remaining participating physicians in the Medical-Surgical Plan of New Jersey. Dr. William Goldring discussed present-day treatment of hypertension during the scientific session.

A regular monthly meeting of the *Passaic County Medical Society* was held on November 17 at Valley View Sanatorium. Dr. Leopold E. Thron, the first vice-president, presided. The following were elected to active membership: Drs. Edward A. Abramo, Wyckoff; Peter E. Hanlon, Paterson. The following were elected to associate membership: Drs. Alphonsus L. Doerr, Clifton; Gerhard R. Hirschfeld and Henry R. Shinefield, Paterson; Spencer C. Manrodt, Pompton Plains.

During the scientific program, Dr. J. Maxwell Chamberlain discussed recent advances in thoracic surgery.

DAVID B. LEVINE, M.D.
Reporter

Together We Progress

MRS. FRANK S. FORTE, *President*

I take this opportunity to wish you all a happy and prosperous New Year.

It is my sincere wish that through our combined efforts the auxiliary shall have a truly progressive year. "Together We Progress" was the theme of the tenth national conference of state presidents and presidents-elect recently held in Chicago with 47 states represented. Mrs. Rauschenbach and I had the pleasure of attending. At the end of the conference we felt proud of New Jersey, for among the many means suggested for promoting this theme all have been applied by our state auxiliary in some form.

Nothing of deeper concern to auxiliary members exists today than that we continue progressing. As we progress, our ideals remain constant but our means of attaining them change.

Every year brings with it new problems and added opportunities, but our auxiliary has demonstrated throughout the years that it is always prepared to face any issue or challenge that presents itself.

As your president it is my hope that you are eager to start the new year with enthusiasm and determination.

Tenth Annual National Conference

The tenth annual conference of state auxiliary presidents and presidents-elect was held in Chicago, November 18-20, 1953. The theme of the conference was "The Relation of Program to Public Relations."

Mrs. Leo J. Schaeffer, national president, stressed the importance of the auxiliary program and emphasized that action was the basis of good public relations. Each member was urged to serve her community.

The main topics of the conference were: (a) how to become better health leaders in local communities, and (b) how to bring medicine's story to the public. Members of the auxiliary were advised to use their programs as a basis for discussing local problems intelligently. The carrying out of our program on a local level is the best way of establishing good public relations.

AMERICAN MEDICAL EDUCATION FOUNDATION

The American Medical Education Foundation is the A.M.A.'s contribution toward preventing government subsidy of our medical schools. This year's goal is \$10,000,000. Local auxiliaries were requested to send in contributions at regular intervals. These are to be mailed to the state chairman who will forward them to the treasurer of the Foundation.

WORLD HEALTH ORGANIZATION

Dr. Franklin D. Murphy, Chancellor of the University of Kansas, summarized the activities of the World Health Organization. He pointed out that disease does not respect national boundaries and that the WHO is striving to help nations solve their own health problems.

LEGISLATION

With the aid of the national Auxiliary program, members were advised to inform themselves about international treaties, tax legislation and medical care programs. Personal contacts with legislators should be established wherever possible. Letter writing should be done on personal stationery.

CIVIL DEFENSE

The urgent needs of Civil Defense were pointed out at this conference. Two hundred and thirty-two workers are needed for each aid station, in addition to physicians and nurses. This personnel would be expected to handle 500 casualties in the first eight hours and 5,000 in the first twenty-four.

NURSE RECRUITMENT

Loans were considered more democratic than scholarships by the majority of the nurse re-

cruitment speakers. The value of Future Nurses Clubs and the use of a special color film entitled "The Girl with the Lamp" were emphasized. This film is available to all auxiliaries through the state chairmen of nurse recruitment.

Today's Health

A plan for soliciting subscriptions to *Today's Health* was presented. It was suggested that each month separate occupational groups be approached for subscriptions, for example, one month beauty salons, next month dentists, etc.

MISCELLANEOUS

The Kansas program for attracting physicians to rural areas was described.

New Jersey was ably represented by Mrs. Frank S. Forte, president, who presented a paper on the history of the American Medical Association. Mrs. David B. Allman, past-president of the national auxiliary, and now a director, gave the invocation.

County auxiliaries were encouraged to develop local mental health programs, with particular attention to the role of teachers in molding the early life of a child.

MRS. PAUL E. RAUSCHENBACH
President-Elect

AUXILIARY REPORTS • •

Essex

Mrs. Stuart Z. Hawkes, president, poured and auxiliary members served as hostesses at the Christmas Seal tea given by the Essex County Tuberculosis League on Friday, November 6, at the Essex County Sanatorium in Verona. Under the leadership of the chairmen, Mrs. Frank Bellucci and Mrs. Anthony D'Addario, members again sold Christmas Seals at a booth located in L. Bamberger & Co. during the pre-Christmas season.

On November 16, 1953, the *Woman's Auxiliary to the Essex County Medical Society* sponsored a program of health education films for the laity in conjunction with the Graduate Week Program of the Academy of Medicine, in Newark. Dr. Stuart Z. Hawkes gave a commentary between the viewing of the films. The program received publicity on television, WATV, on November 13, and on radio, WAAT, the following day. Dr. Herbert Schulte, board chairman, Dr. Edward Klein, Jr., president of the Academy of Medicine of New Jersey and Dr. Stuart Z. Hawkes, chairman of the Graduate Week committee, appeared on the television show. Mrs. Jesse Glazier, chairman, has received a number of requests from lay groups for a loan of the films viewed.

On November 23, 1953, at our regular monthly

meeting, safety chairman Mrs. Harry McCluskey had a very interesting display of causes of home accidents to children. The props were borrowed from the New Jersey State Safety Council. One of the aims of this committee is to familiarize the public with the many accident hazards to children. The increase has been alarming and is due in part to new detergents and mechanical home appliances now in use. Literature was distributed containing suggestions for the elimination of some of these hazards.

MRS. HARRY E. DIGIACOMO
Chairman, Press and Publicity

Hudson

The *Auxiliary to the Hudson County Medical Society* gave a Christmas party at the Y. W. C. A. in Jersey City, on December 3, 1953.

Mr. Phillip Cartwright, baritone, was soloist. His vocal selections were appropriate and beautifully rendered. Mr. Cartwright came to us through the courtesy of our president, Mrs. William Loori.

Mrs. Camilla Dandekow of South Orange demonstrated how to decorate the home for Christmas. Her contribution was interesting and original.

MRS. MOSES DOLGANOS
Publicity Chairman

Many of the Reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

The Surgery of Infancy and Childhood. By Robert E. Gross, M.D., and William E. Ladd, Professor of Children's Surgery, Harvard Medical School, Surgical Service, The Children's Hospital, Boston, Pp. 1000, Phila., W. B. Saunders Co., 1953. (\$16.00)

This book will, without question, succeed as the "bible of pediatric surgery" the previous volume written by these authors twelve years ago. However, as the title implies, this book is not confined to the abdomen, but encompasses the subjects of thoracic and cardiovascular surgery, the advances in which Dr. Gross, himself, has so prominently figured.

The book is written in a readable style with 1,488 illustrations explaining visually the many technical procedures involved.

Congenital megacolon (Hirschsprung's disease) is a condition whose etiology was poorly understood and treatment far from standardized in 1941. The new chapter summarizes the postwar work of Hiatt and Svenson with the "pull-through" operation illustrated in a series of twenty-one easily understood drawings.

The subject matter on malformation of the anus and rectum is drawn from an experience with 507 cases. Here again there is an excellent discussion of the abdomino-perineal approach to the high lying rectum with simultaneous division of any associated fistula.

The chapter on atresia of the esophagus comprises an experience with 217 cases since 1941 and is again particularly well illustrated. The survival rate has now been raised to 67 per cent in 1952 (21 cases) one of the successful cases including a 2 pound, 15 ounce premature infant.

The chapters on cardiovascular surgery must of necessity in a book of this type be somewhat superficial although it is difficult to see what Dr. Gross has left out. He writes from a personal experience with 611 cases of patent ductus carrying an overall mortality rate of 1.7 per cent since 1944. (In cases with no infection or decompensation, the mortality was 0.5 per cent). Coarctation of the aorta comprises a series of 270 cases. In the first 100 there were 15 deaths, in the last 100 there have been but 2. These chapters are again accompanied by superb illustrations.

This book is a masterpiece of its kind and will provide information and inspiration to anyone dealing, however infrequently, with pediatric surgery.

O. B. CARTER, JR., M.D.

Sectional Radiography of the Chest. By Irving J. Kane, M.D., Consultant in Chest Diseases, United States Naval Hospital, St. Albans, N. Y. Cloth. Pp. 154. New York, Springer Publishing Co., Inc., 1953. (\$7.50)

Sectional radiography is the layer by layer study of body tissues. It is sometimes called planigraphy, tomography and laminography. It is accomplished by moving the x-ray tube and film in opposite directions during the period of x-ray exposure. By this method, objects in the selected plane of radiography remain in focus while those in other levels, above and below or anterior and posterior to the plane of focus, are erased or blurred out.

The principles of sectional radiography have been known for a long time and have been described by various authors. Dr. Kane has reviewed previous works on this method and has made a major contribution through his own experiments and clinical studies. The book is divided into four main sections with the following titles: (1) Principles and Methods, (2) Selection of Position and Levels, (3) Anatomy, (4) Pathology.

In the first chapter, under principles and methods, there is a review of the different methods of sectional radiography with the advantages and disadvantages of each. Paragraphs are also devoted to means of best accomplishing the desired results with different exposure technics.

The selections of position and levels at which one should concentrate his attention in sectional radiography have always been a problem to the radiologist. It is an individualized study which can only give good results by carefully choosing the levels to be examined and knowing the areas in which pathology exists. These positions will always be influenced by the preliminary conventional chest x-ray. The various types of pathology require selection of different positions and levels of interest for sectional radiography. Both the number of films and the spacing of the intervals at which the films are to be taken should be determined by the conventional chest x-ray. Economy can be accomplished by careful selection of these intervals and levels. Dr. Kane has devoted considerable space to the anatomy of the chest and the relationship of the different structures so that one may select the level of examination with greater accuracy. If the levels are selected properly the exact relationship of a lesion in the chest to the surrounding structures can be very well delineated. This is of inestimable value to the surgeon.

The chapter on pathology is very well covered with many excellent illustrations showing the ad-

vantage of sectional radiography over the orthodox conventional film. Sectional radiography is of special value on demonstrating cavities which cannot be seen in conventional film, either because of their location or because they are obscured by superimposed pathology anterior or posterior to the level of the cavity. This is especially true in those cases of advanced pneumoconiosis complicated by tuberculosis. It is also of great value in revealing metastatic tumors of the chest and small lesions of the bronchi.

Dr. Kane has included a very extensive bibliography and an excellent index.

FRANCIS P. CARRIGAN, M.D.

Living with a Disability. By Howard A. Rusk, M.D., Director of the Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center, and Eugene J. Taylor, Asst. Professor of Physical Medicine and Rehabilitation, Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center; in collaboration with Muriel Zimmerman, O.T.R. and Julia Judson, M.S. Pp. 207. Garden City, N. Y., Blakiston Company, Inc., 1953. (\$3.50)

As Dr. Rusk explains in the foreword to this useful manual, when a device makes it possible for a physically handicapped individual to accomplish something which he could not do without this assistance, that device becomes an important adjunct to the total rehabilitation program. Of course the handicapped should do as many things as is possible without special assistance.

Living with Disability is a collection of photographs and drawings of self-help devices for the disabled. A brief text accompanying each picture illustrates clearly how to secure or construct the particular gadget. No extravagant claims are made for any of the devices shown; when there are disadvantages to the use of any tool these are mentioned.

Assistive devices for eating, dressing, grooming, working, traveling and playing are shown. Any one of these may well spell the difference between independence and dependence in the handicapped person's ability to perform the activities of daily living. The manual will be very useful to handicapped persons and to those who are concerned with their rehabilitation.

HENRY H. KESSLER, M.D.

Endocrinology in Clinical Practice. Edited by Gilbert S. Gordan, M.D., Assistant Professor of Medicine, University of California School of Medicine, and H. Lissner, M.D., Clinical Professor of Medicine and Endocrinology, University of California School of Medicine. Pp. 407. Chicago, The Year Book Publishers, Inc., 1953. (\$10.50)

Advances in endocrinology have been so rapid in the past ten years that important publications in this field become obsolete shortly after they become available. The appearance of the above book is a welcome addition to the library of the general

practitioner, as it deals with simplified methods of diagnosis and treatment of endocrine disturbances.

Our present knowledge in clinical endocrinology is brought up to date particularly as far as therapy is concerned. Of special interest are chapters on thyrotoxicosis, metabolic bone diseases, the adrenals and the diagnosis of functional sterility. In the chapter on thyrotoxicosis the choice of appropriate therapy in each individual case is thoroughly discussed and the relative merits and indications for surgery, thiourea compounds and radioactive iodine are evaluated.

In the chapter on metabolic bone diseases differential diagnosis is clarified and general and hormonal therapies discussed.

In the chapter pertaining to the diagnosis of menstrual disturbances and functional sterility the evaluation of the vaginal smear, endometrial biopsy and the basal body temperature are discussed in detail and are well illustrated by charts and histologic pictures.

Other phases of clinical endocrinology are also covered adequately.

RITA S. FINKLER, M.D.

Therapeutics in Internal Medicine. Ed. by Franklin A. Kyser, M.D., Assistant Professor of Medicine, Northwestern University Medical School. 2nd. ed. Pp. 830. New York, Paul E. Hoeber, Inc., 1953. (\$15.00)

Eighty-four authors under the editorship of Dr. Kyser have compiled this almost complete encyclopedia of methods of treatment in internal medicine. Seventy-five per cent of the contributors to this volume are from midwestern and farwestern medical schools. Of the total only twenty-nine authors are from the eastern United States. Nevertheless, the present status of internal medicine is such that readers accustomed to an eastern point of view will not find any strange or radical theories set forth in this book.

As is customary in texts dealing with internal medicine the material is arranged first according to general diseases and then by organ system. The first two chapters deal with infectious diseases including those due to viruses, bacteria, rickettsia, and finally the protozoan parasitic infections. The third and fourth chapters are concerned with diseases of metabolism and fluid and electrolyte balance. Then follow chapters on endocrine disorders, deficiency diseases, and these are followed by the usual system arrangement which considers successively the digestive tract, the respiratory system, the cardiovascular system, diseases of the blood and blood forming organs, the urinary tract, the locomotor system, allergy diseases, those due to physical agents, intoxicants, diseases of the nervous system and finally the skin. Lastly there is a chapter on symptomatic treatment.

The book can be commended for its excellent presentation of such a large amount of material. Although little space is devoted to problems of diagnosis, enough is given to provide suitable background for the therapeutic methods that are proposed. Each individual disease entity is discussed under the headings of prophylaxis, active treatment

and supportive therapy. In each case where applicable, specific drugs are described with their dosage and method of administration. Several therapeutic methods are described for each disease and a critical analysis of each is given. Little space is wasted on prolonged dissertation concerning obscure and rare diseases. For example Weber-Christian disease (relapsing febrile nodular nonsuppurative panniculitis) is covered with this single paragraph: "The etiology of this rare clinical entity is unknown and there is no specific treatment. Recently a few reports have appeared of the beneficial effects of ACTH and cortisone."

Of particular interest are the excellent tables which are presented where indicated. For example, in the discussion of diabetes detailed diets are shown. A figure illustrates clearly the various hypoglycemic effects of the different insulins and insulin mixtures (page 231). The management of all forms of diabetes, the mild, severe and labile, is clearly and adequately discussed. Complications of diabetes, such as acidosis and coma are considered in detail. Treatment of diabetic retinitis is described as unsatisfactory. The postamputation management of diabetic gangrene is also given.

Particular commendation should be given for the brief but excellent discussion of problems of fluid and electrolyte balance. Acidosis and alkalosis in both metabolic and respiratory forms are described. A discussion of diagnostic tests for pheochromocytoma is given. Adequate space is devoted to thyroid and parathyroid disease. There is a critical analysis of the use and abuse of vitamins in internal medicine.

A book of this type can be recommended for every internist who desires a reference in the field of therapeutics and for general practitioners who wish to obtain a fairly detailed knowledge of the principles of medical therapy. The only criticism that can be made of a book of this type is its necessary short period of usefulness. Progress in therapeutics is so rapid today that such a volume rapidly becomes outdated. However, this particular edition contains enough material of basic importance so that it should serve as a ready reference on the bookshelves of practicing internists.

The editors are to be especially complimented on the excellent organization of the material, the clarity with which it is presented, and the publishers deserve credit for an easily readable style of body type with clear chapter headings and sub-headings for each individual topic.

R. D. GOODMAN, M.D.

Mental Health Implications in Civilian Emergencies. United States Public Health Service, Pp. 25. Government Printing Office, Washington 25, D. C., 1953. (\$0.15)

Questions are asked rather than answered in this thought-provoking pamphlet. Unfortunately the reader is so heckled by footnotes that it is hard to

wend one's way through the text. (There are only 25 pages but the editors have packed in 91 footnotes, many of which are a full page each! This is probably something of a record in text-footnote ratios). What the brochure does for the reader is to organize his thinking into such categories as: care of the emotional casualty, prevention of panic, handling of children, development of motivations, distribution of public information and the like. Under each heading numerous questions are raised, so that the student of the subject can work out the answers with the aid of the references cited in the footnotes. On the whole, the pamphlet crowds a lot of common sense into the narrow margins left by the footnotes.

HENRY A. DAVIDSON, M.D.

Sexual Behavior in the Human Female. By the Staff of the Institute for Sex Research, Indiana University, Alfred C. Kinsey, Sc.D., Wardell B. Pomeroy, A.M., Clyde E. Martin, A.B., and Paul H. Gebhard, Ph.D., Research Associates. Pp. 842. Phila., W. B. Saunders Co., 1953. (\$8.00)

The widespread advance publicity given this volume in all parts of the lay press has generated an excessive interest in a delicate subject. The authors have applied all of the technics of scientific research to an analysis of the sexual behavior of nearly 8,000 women over a period of fifteen years. Unfortunately, the sample taken is not representative of a true cross section of our country since it is far too heavily weighted with individuals of the higher education groups, especially of those in graduate study. In contrast to the earlier companion volume on the sexual behavior of the male, this study will not lend itself to sweeping conclusions about the sexual habits of the female.

The 18 chapters of this volume try to analyze the complex maze of sexual behavior in terms of response, i.e. orgasm, which might be the best means to measure an intangible of this nature but leaves an analytic appraisal in some doubt as to the validity of conclusions drawn from the study. The real value of the analysis, to this reviewer, lies in the application of bona fide scientific research technic to a subject which has been an enigma to the average American. It presents an honest attempt to open an intricate subject that must receive the attention of our educators.

For the physician engaged in treating the female, or in marriage counseling, Kinsey's report will serve as an excellent reference work.

The final five chapters, covering the anatomy, physiology, psychology, neural mechanisms, and the hormonal factors in sexual response, summarize thoroughly all of the known facts about these subjects in sexual behavior. Generally speaking, *Sexual Behavior in the Human Female* is a good approach to creating better understanding of man in one of his more difficult aspects.

IRVING K. PERLMUTTER, M.D.

The Anatomy of the Nervous System; its Development and Function. By Stephen Walter Ranson, M.D., late Prof. of Neurology and Director of Neurological Institute, Northwestern University Medical School. Revised by Sam Lillard Clark, M.D., Prof. of Anatomy, Vanderbilt University School of Medicine. 9th ed. Pp. 581. Phila., W. B. Saunders Co., 1953. (\$8.50)

In the 33 years since the first edition was published, this book has gained a secure place among textbooks on anatomy. After the senior author's death, a partial revision for the eighth edition was carried out by Dr. Clark in 1947. In this second revision by Dr. Clark for the ninth edition, further and more extensive changes have been made. Many portions of the text have been completely rewritten; the present edition, therefore, is practically a new publication.

It is the intent of the authors to present the anatomy of the nervous system from the dynamic rather than the static viewpoint. Emphasis is placed on the developmental and functional significance of structure since they believe that structural details become interesting when their functional significance is made obvious. Numerous clinical illustrations are found throughout the text, but of special interest is a section of clinical cases which presents typical case histories with the neuroanatomic correlation.

A section which deals with the various level lesions of the central nervous system is also felt to be noteworthy. One can readily study the effects of focal lesions at any given point in the nervous system. An outline for a laboratory course in neuroanatomy has been included and is arranged for easy adaptation by the instructor to his particular needs. A bibliography of 20 pages and the index itself give evidence of thorough scholarship.

The reviewer considers this an excellent reference work for the neurologist and neurosurgeon.

HAROLD M. SOMBERG, M.D.

Films in Psychiatry, Psychology and Mental Hygiene. By Adolf Nichtenhauser, M.D., Marie Coleman and David Ruhe, M.D. Published for the Association of American Medical Colleges by the Health Education Council, 10 Downing Street, New York City 14. Pp. 269. 1953. (\$6.00)

Six dollars may seem like a high price for a 270 page book. This, however, is no ordinary book. It is, all in one neat package, a permanent catalogue of mental hygiene films, a gallery of selected frames from those films, a guide to audiences appropriate for various types of films, a handbook for discussion leaders at mental hygiene meetings, a source book on films, a manual of hints on proper display, and a depository of thoughtful reviews.

Some fifty mental hygiene films are reviewed in considerable detail, and forty more are reviewed briefly. For each film, the reader is told the time it takes, where to get the film, the appropriate audience, and the most effective method of presentation. Each film is carefully appraised. In the endpapers is a ready reference guide to the films classed by audience types. In the index, the sub-

ject matter of each film is broken down and distributed under topical headings.

Also included is a chapter on film reviewing technics, a chapter on the utilization of films in teaching, and a historical account of the role of motion pictures in psychiatric pedagogy.

The book is a *vade mecum* for any doctor who speaks frequently to lay groups, parent-teacher associations and the like. It belongs in the official library of every mental hygiene society, medical school faculty, child welfare agency, and psychiatric association. As new films come out, new editions will be necessary. But this 1953 edition, the first of its kind, will probably be a collector's item before the decade is up.

HERBERT S. BOEHM, M.D.

Surgery of the Biliary Tract, Pancreas and Spleen.

By Charles B. Puestow, M.D., Clinical Professor of Surgery, College of Medicine and Graduate College, University of Illinois. Pp. 370. Chicago, Year Book Publishers, Inc., 1953. (Handbooks of Operative Surgery series) (\$9.00)

For a concise and very informative treatise on the practical features of surgery of the organs indicated by the title, this volume is very valuable. Limitations of space keep the text sketchy yet do not omit important points; the illustrations of procedures complement the text in a clear manner.

The chapter and illustrations on repair of injury to the bile ducts are particularly clear as is the description of dislocating the liver for easy access to the ducts. A few points do lack clarity, for example, closure of the bronchial part of the hepato-bronchial fistula and the differential diagnosis of acute pancreatitis. The volume, however, reads easily and gives a live presentation of the subject.

A. STRELINGER, M.D.

Holt Pediatrics. By L. Emmett Holt, Jr., Professor of Pediatrics, New York University College of Medicine and Rustin McIntosh, Carpentier Professor of Pediatrics, Columbia University. 12th ed. Pp. 1485. New York, Appleton-Century-Crofts, Inc., 1953. (\$15.00)

In this new 12th edition, Drs. Holt and McIntosh have correlated their own viewpoint with that of 72 collaborating authorities. As a result of this collaboration, there is a unity of approach and a proper emphasis placed on each subject. Much unnecessary detail has been omitted and concise treatises are the rule.

Individual subjects are adequately covered. Dwarfism, nutritional requirements, disorders of the nervous system, infectious diseases, particularly tuberculosis, are well presented. The subject of general considerations of psychopathologic problems is excellently discussed. There are a few subjects, however, such as fluid balance, ACTH and cortisone therapy, that are sketchily covered.

This new edition is highly recommended.

JOSEPH E. MAST, M.D.

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ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

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No. 1

**THE AGE RELATIONSHIP OF CASES OF PULMONARY
TUBERCULOSIS AND THEIR ASSOCIATES**

By *Arthur B. Robins, M.D., American Journal of Public Health, June, 1953.*

The most significant recent trend in the epidemiology of tuberculosis is the degree to which the disease is affecting older people, particularly older men. In 1932, 37 per cent of the deaths from pulmonary tuberculosis in New York City occurred in individuals 45 years and over, and 78 per cent of these deaths were among males. At this time only one-quarter of the newly reported cases of pulmonary tuberculosis developed in this age group, and less than one-fifth among older men.

By 1950, less than 20 years later, the proportion of new cases and deaths from pulmonary tuberculosis occurring in persons 45 and over had doubled. More than 65 per cent of the residents of New York City who died of the disease were 45 and over, and men were responsible for 85 per cent of these deaths. Similarly, almost half of the newly reported cases of pulmonary tuberculosis were now found in people 45 and over, and males in this age group contributed 36 per cent of all new cases.

During this same period a sharp decline in the percentage of children reacting to the tuberculin test was noted. The mortality from all forms of tuberculosis in persons under 10 years of age reached an all-time low. A major factor in these reductions was undoubtedly the decrease in tuberculosis infection in the community. This decline can be attributed to the presence of fewer communicable cases of the disease, their more effective isolation, and the increased resistance of exposed individuals resulting from their improved standard

of living. In addition, another possible explanation of the much sharper decline in tuberculous infection in childhood presents itself. Could fewer children under 10 have been exposed to household infection during recent years because source cases were older and less likely to have younger children living with them?

To test this hypothesis a study of the households of persons with pulmonary tuberculosis first reported in 1950 was undertaken. Only male index cases were included, since it had been demonstrated that the postponement of the age of peak morbidity and mortality from tuberculosis was due primarily to the shift toward the older ages in males. A sample of 778 cases was selected at random from the total of 3,467 men more than 25 years old with pulmonary tuberculosis reported for the first time in 1950. The results may be summarized as follows:

1. Study of representative samples of the households of males 25-44 years of age with pulmonary tuberculosis and those 45 and over, reported in New York City in 1950, reveals characteristic variations in their composition.

2. Older individuals with tuberculosis have fewer household members, and their associates are less frequently under 10 years of age than younger persons with the disease.

3. These differences may have been a major factor in the relatively greater reduction in tuberculous infection, morbidity, and mortality in childhood over the past 20 years.

4. This factor may contribute materially to the rapid rise in the incidence of tuberculosis which occurs in adolescents and young adults.

The observations show some of the effects pro-

duced by the shift in tuberculosis morbidity to the older ages, particularly in men. As previously mentioned, the proportion of new cases reported in males 45 and over has doubled in less than a generation. Not only is pulmonary tuberculosis more frequent in older men, but it is also in a more advanced stage at the time of discovery. Fifty-six per cent of males 45 and over, compared with less than 40 per cent of men 25-44, newly reported as tuberculous in New York City in 1950, had far advanced disease at the time of report. The difference in the number of associates exposed to massive infection in the households of the two groups was even greater.

As a result of these differences the risk of tuberculous infection in certain segments of the population has been materially altered. The danger of contagion has become greater for the associates of older patients, and less for the associates of younger patients of tuberculosis. This statement applies particularly to the immediate households of tuberculous individuals. Study of such households shows that they vary in several important respects. Parents and siblings make up a larger proportion of the associates of male patients, 25-44 years of age, than of the associates of older men with the disease. Descendants of all ages are somewhat more frequently present in the homes of patients 45 and over. On the other hand, if consideration is given to the size of the household, a different picture is presented. Two-thirds of the older men with tuberculosis are without household associates, or list only one, presumably a spouse. By contrast, 53 per cent of the younger patients have no, or only one, household contact. The sample studied contains an average of 1.9 household associates for each male patient with tuberculosis under 45, and 1.4 household associates for each 45 and over at time of report.

The aspect of the subject of greatest interest is the age of the associates in relationship to the age of the index case. Comparison of the households of the two groups of patients indicates a marked concentration of young children in the homes of younger men with tuberculosis. When

marital partners are excluded, more than 37 per cent of the associates of the younger group are under 10 years of age, which is more than twice the proportion of children found among the associates of males 45 and over. Individuals between 10 and 34 form a significantly greater part of the households of older patients, primarily as a result of the large number of 15- to 24-year olds included among them. The same trends, with minor variations, characterize the age distribution of male and female household members considered separately.

The implications of these findings in the epidemiology of tuberculosis are far-reaching. There is general agreement that the level of tuberculous infection in the community has become lower during the past 20 years as a result of the reduction in the number of communicable cases. A more rapid decrease in the extent of the tuberculosis problem in children has also been noted, but no adequate explanation for it has been advanced. This study would suggest that the relationship between the age of household associates and tuberculosis may be the major factor responsible.

It has been demonstrated that a selective reduction in the opportunities for exposure of young children accompanies the aging of the tuberculous population. Its superimposition on the universal drop in infection could readily account for the phenomenal recent decline in the percentage of tuberculin reactors under 10 years of age. The same influence would also lead to a relatively increased risk from tuberculosis among adolescents and young adults. Having escaped contact with the tubercle bacillus in childhood, they would be more apt to encounter it for the first time between 10 and 34. The sharp rise in the incidence of new cases characteristic of this age group may well be a reflection of the greater morbidity which follows the resulting primary infections in adult life. There is reason to believe that the relationship between the age of associates and tuberculosis will be a factor of growing importance in tuberculosis.

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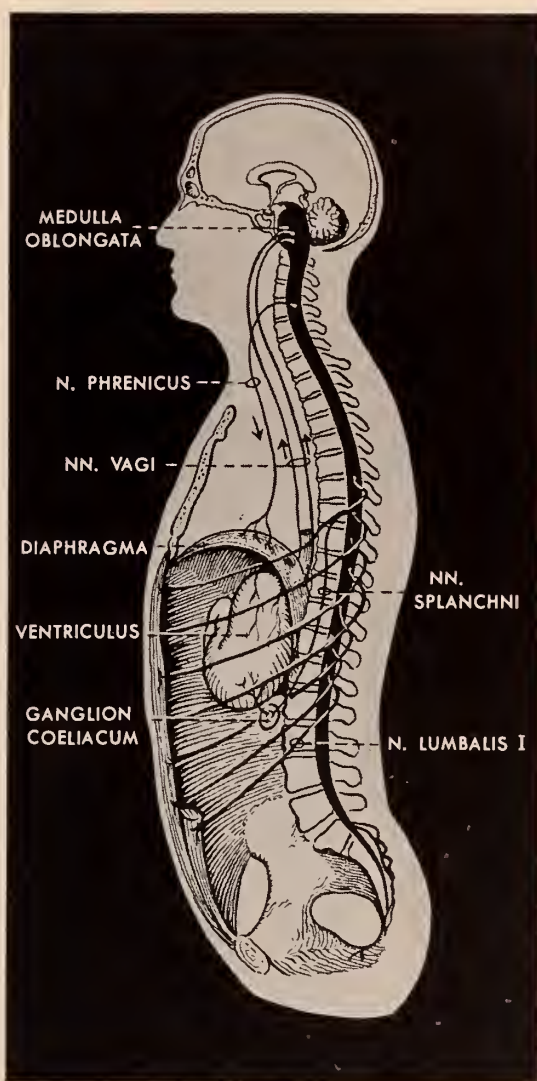
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1. Keats, S.: Ataxic Cerebral Palsy with Akinetie Seizures: Dramatic Response to Dramamine, J. M. Soc. New Jersey 50:53 (Feb.) 1953.
2. Council on Pharmacy and Chemistry: New and Nonofficial Remedies, 1953, Philadelphia, J. B. Lippincott Company, 1953, p. 471.



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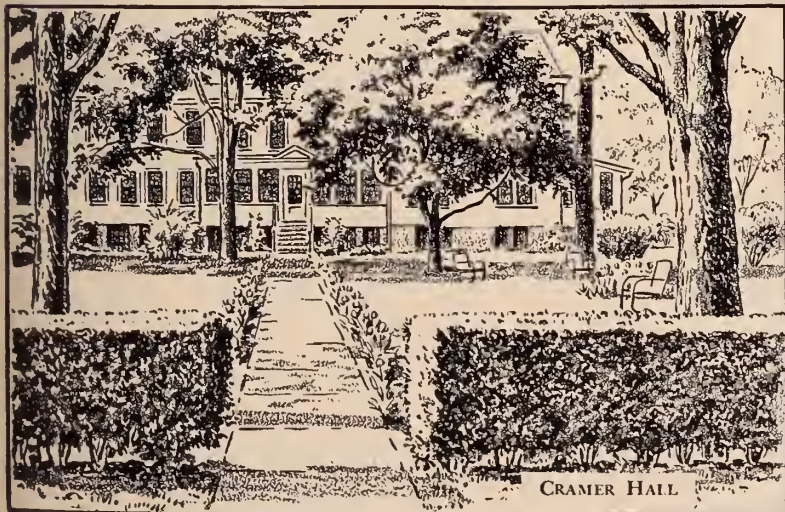
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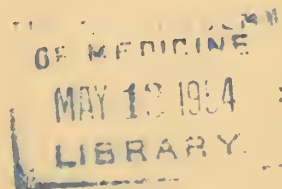
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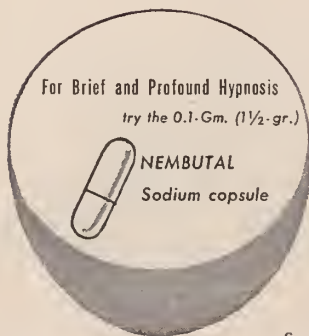
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Calcium Gluconate	65.0 mg.
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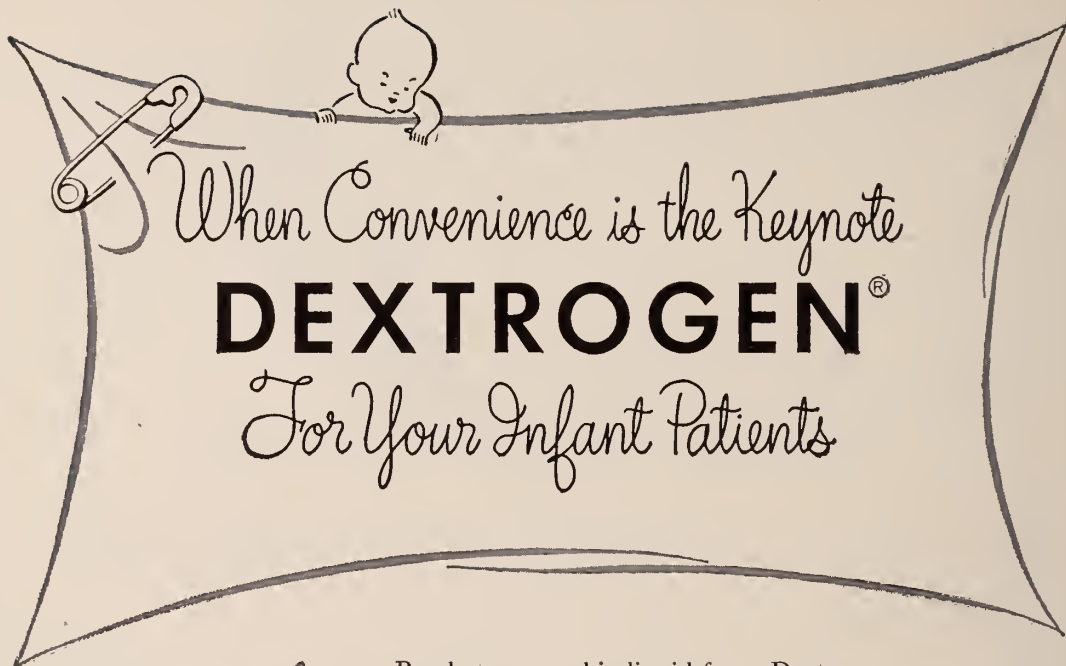
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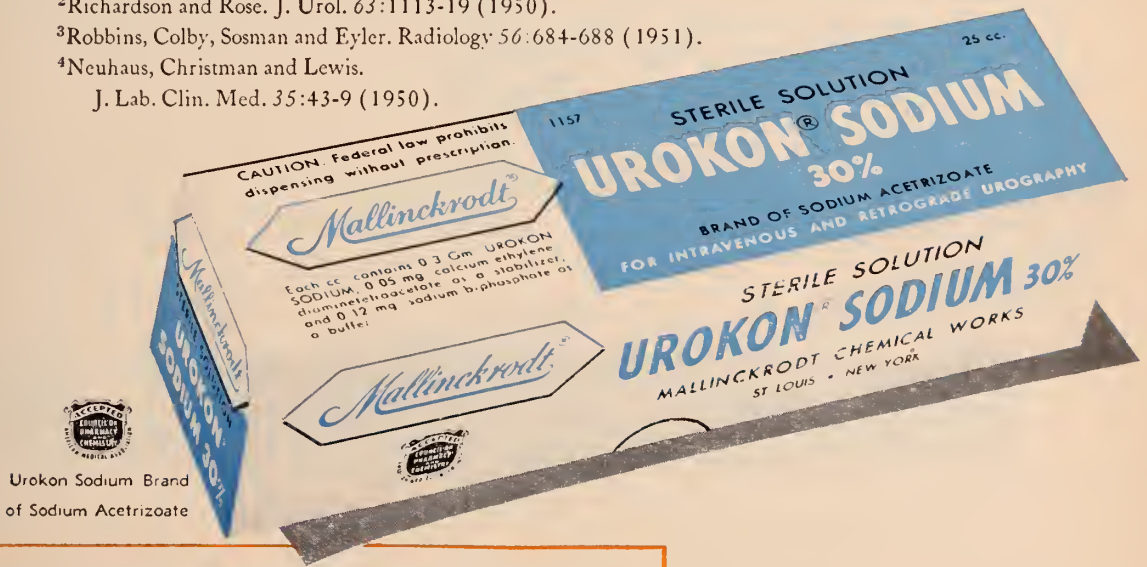
¹Nesbit and Lapidus. Univ. Michigan Med. Bull. 16:37-42 (1950).

²Richardson and Rose. J. Urol. 63:1113-19 (1950).

³Robbins, Colby, Sosman and Eyer. Radiology 56:684-688 (1951).

⁴Neuhaus, Christman and Lewis.

J. Lab. Clin. Med. 35:43-9 (1950).



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1. Werner, A.: Acta endocrinol. 13:87, 1953.

2. Malleson, J.: Lancet 2:158 (July 25) 1953.

3. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 23.

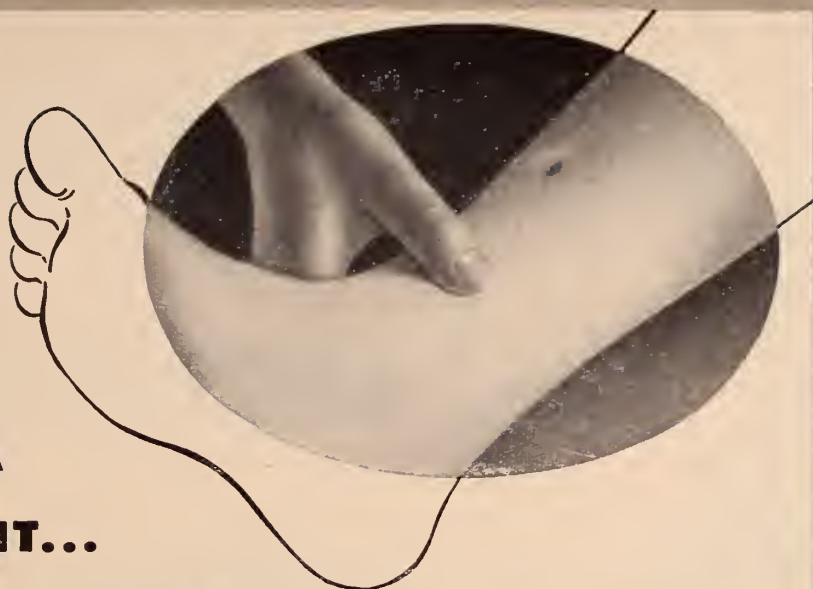


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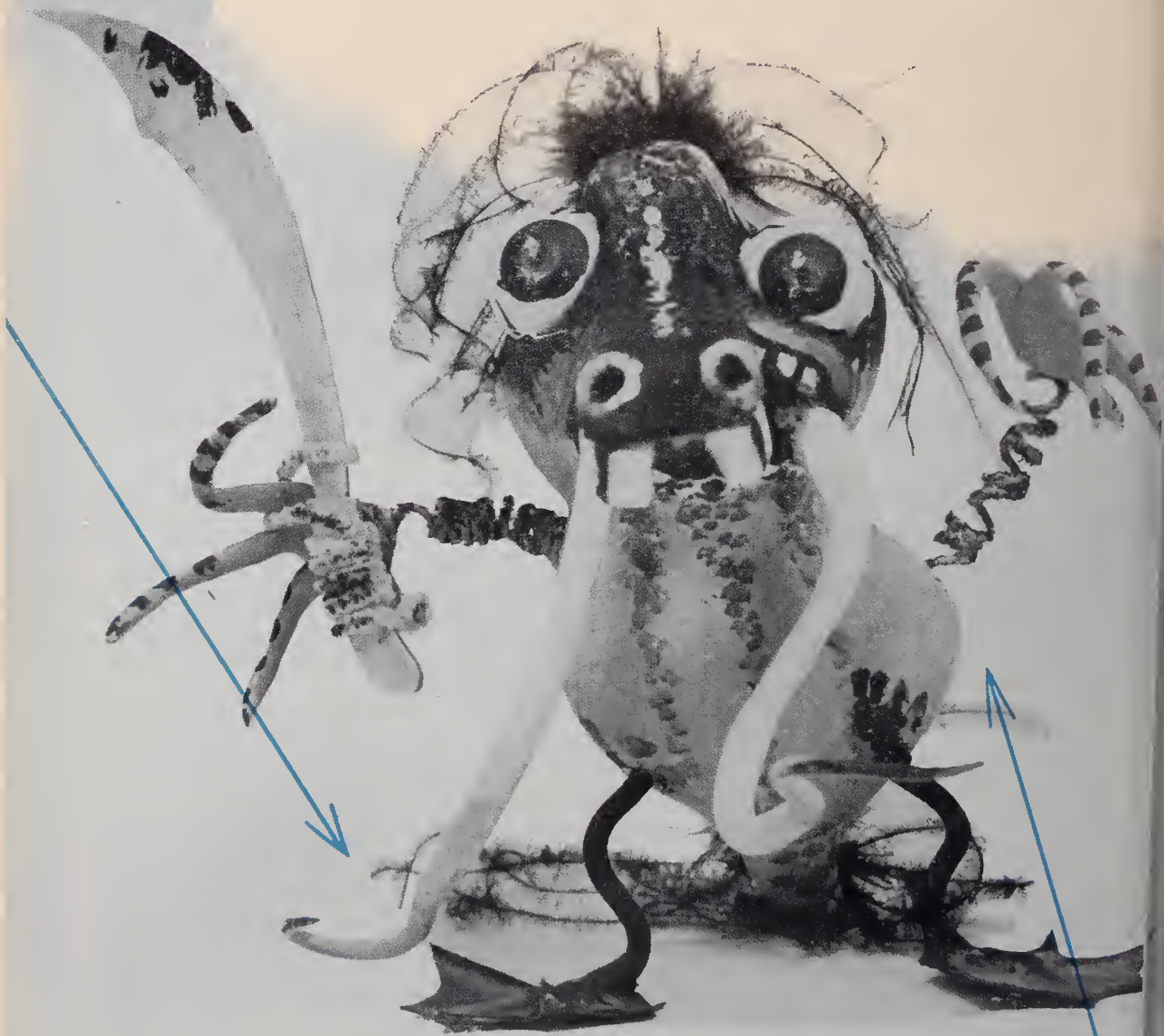
1. Abromson, Julius, Bresnick, Elliott, and Sapienza, P. L.: *New England Jour. Med.*, 243:44, July 13, 1950.

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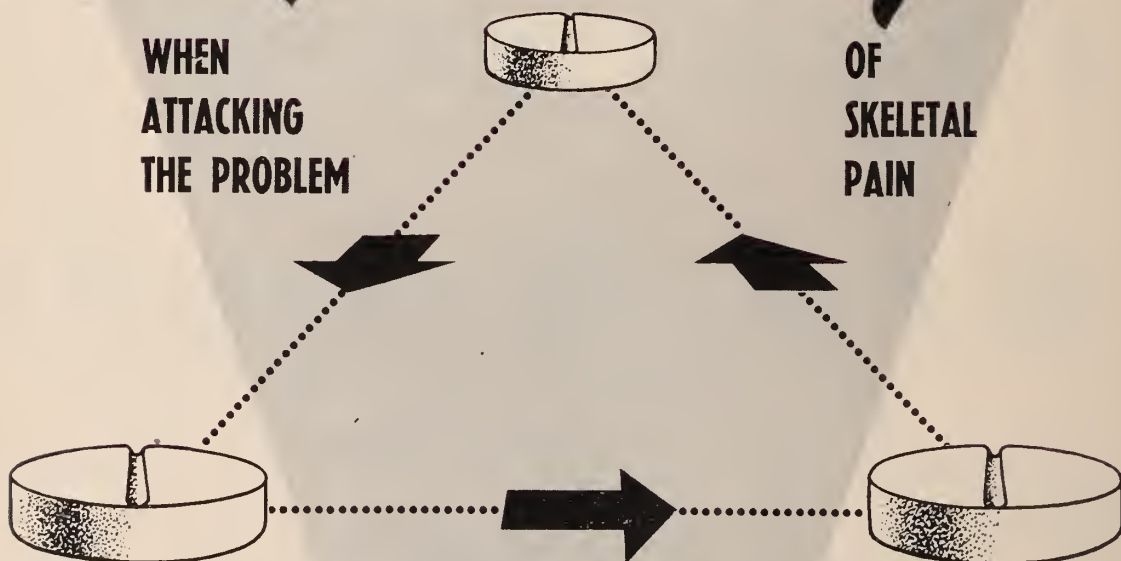
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1. Grigsby, M. E., et al., *Antibiot. & Chemother.*, 10:1029, October, 1953.

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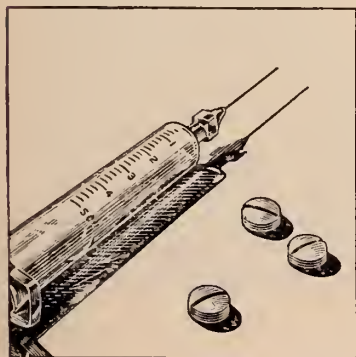
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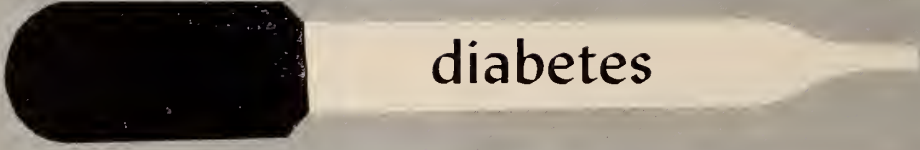
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1. Sayer, R. J., et al.: Am. J. M. Sc. 221:256 (Mar.) 1951.
2. Welch, H.: Ann. New York Acad. Sc. 53:253 (Sept.) 1950.
3. Werner, C. A., et al.: Proc. Soc. Exper. Biol. & Med. 74:261 (June) 1950.
4. Wolman, B., et al.: Brit. M. J. 1:419 (Feb. 23) 1952.
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***Data from nationwide poll: Diabetes in daily practice**

70% were over 40.

40% had a family history of diabetes.

65% were overweight.

1. Blotner, H., and Marble, A.: New England J. Med. 245:567 (Oct. 11) 1951.

2. Steine, L.: GP 8:45 (July) 1953.

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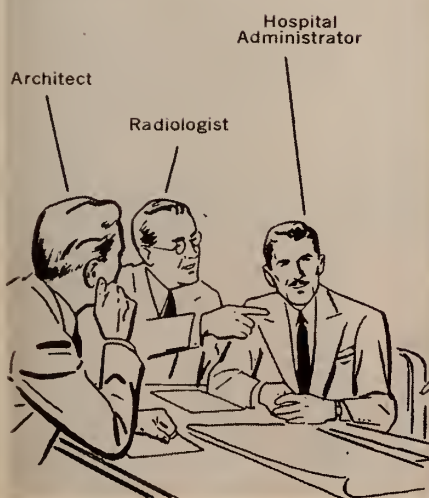
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Glazebrook, A. J., Brit. M. J.,
2:1328, (Dec. 20) 1952.

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*Stead, E. A., Jr., in Cecil, R. L., and Loeb, R. F.: Textbook of Medicine, ed. 8, Philadelphia, W. B. Saunders Co., 1951, p. 1065.

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Bibliography: 1. Humphreys, P., *et al.*: *Angiology* 3:1 (Feb.) 1952. 2. Russek, H. I.; Urbach, K. F.; Doerner, A. A., and Zohman, B. L.: *J.A.M.A.* 153:207 (Sept. 19) 1953. 3. Plotz, M.: *New York State J. Med.* 52:2012 (Aug. 15) 1952.

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The book review section is one of the most important departments in this JOURNAL. Its purpose is to assist the busy physician in selecting books which may be of interest to him. A great deal of attention is given to providing reviews of good quality, to assist our readers in deciding which books they wish to read. Most books for review are distributed by the librarian of the Academy of Medicine of New Jersey; a few come directly from the editorial office.

What are the ingredients of a good book review? They consist of answers to these questions:

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- 2) What is the author's purpose in writing it?
- 3) Does the author succeed in his purpose?
- 4) How is the book technically?
- 5) How does the book compare with others on the same subject?

For what readers the book is intended, is of great importance. A book may be written to appeal to all practicing physicians, to spe-

cialists in a given field, to students, or to a very narrow group. Since the publishers naturally like to have the book sold as widely as possible, advertising copy and jacket blurbs may be misleading. For instance, a recently-reviewed volume entitled "Biological Antagonisms" was a very complex biochemical treatise, of little appeal to the average physician. In this instance the book was poorly titled, giving promise of more general interest than it provided. A similar example is Shaffer's "Cardiology," with a general title belied by the author's own statement in the preface that it is intended as an introduction to electrocardiography. An experienced cardiologist would have been disappointed had he purchased this book sight unseen.

The purpose of the book is often set forth in the preface and is extremely important for the prospective purchaser. For instance, a book entitled "Principles of Surgery," may be intended merely as an outline guide for fourth year medical students or it may be designed to provide a practical guide for general practi-

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tioners who do surgery; or, it may be a complete, detailed compendium of all surgical technics and principles which have accumulated through the ages. Obviously, the reader's interest will depend on what the book is trying to achieve.

The next question is how well the author succeeds in his purpose. Is the new edition of a text really up-to-date, or merely a rehash of the last one? If a new idea is propounded, is it well backed with convincing evidence? If the author claims completeness, is he really comprehensive in his coverage of the topic under consideration? These are the kinds of questions the reviewer asks himself as he goes through the book.

The technical aspects include not only questions of typography, paper, binding, illustrations and figures, but also the accuracy of material presented, validity of conclusions drawn, style of writing, readability, the quality of the bibliography and the index, and similar items.

Many books which appear allegedly offer a new approach to an old subject. Hence, it is important for the reviewer to be familiar with other literature in the field. For example, a new text on anatomy must compare favorably with the standard ones, otherwise there is no reason for the purchaser to spend money on a book inferior to one he may already have. This is particularly true with "comprehensive"

texts on medicine, surgery, obstetrics, etc. Unless something new in the way of material or presentation is offered, the older book will probably suffice.

A book "review" which merely lists the contents, states that the figures are lovely, or quotes from the publisher's publicity is valueless. Such a review is an affront to the reader, the author, and to the publisher who is kind enough to send a free copy for review.

The value of a good book review to the publisher, plus a summary of its attributes, is described by Martin Matheson¹ in a recent issue of *Science*:

It is not out of order, it seems to me, to make some comments on the part played by the review in selling books. Two years ago Wiley (John Wiley and Sons, Inc., New York) ran a study on the effectiveness of various selling methods. The results showed that critical reviews ranked immediately behind direct-mail advertising. I use the word "critical" advisedly in describing a book review. Too many reviews consist of a summary of the book's contents; others repeat the publisher's jacket blurb or his circular copy. The review that really is significant and useful to potential readers is the one that can be written only by an authority in the field who has given the book careful study. He must even read the preface to make certain he understands what the author has tried to do, and above all what he has intentionally omitted. The signed review, the practice of most of the better scientific journals,* is usually a much better performance than the unsigned one. If a book reviewer knows that his comments will appear over his name, he will in the nature of things exercise more care and will be more thorough in evaluating the book. In the final analysis, he is working for the prospective user, and stating as frankly as he can whether a book should be bought or avoided.

1. Matheson, M.: Selling Books to Scientists. *Science*, 117:406. April 17, 1953.

* All book reviews in this JOURNAL are signed, for the reasons given by Matheson.

Isoniazid in Tuberculosis

On page 50 of this issue of the JOURNAL Drs. Segal and Chakravarty report their results in treating eighty-nine tuberculosis patients with isoniazid and iproniazid. Their findings indicate that these two drugs when used alone are of value in treating three particular aspects of pulmonary tuberculosis: 1) By producing beneficial systemic effects on appetite and fever and a sense of well being, many patients were

so improved clinically that definitive therapy, such as collapse or surgery, could be applied; 2) Improvement in the exudative phase of tuberculosis was achieved; 3) Certain patients, whose sputa continued to contain tubercle bacilli after surgery, were rendered bacteriologically negative.

These results are of special interest in light of other studies which have been reported con-

cerning the treatment of pulmonary tuberculosis with chemical agents. Tucker,¹ writing in the *Annals of Internal Medicine* for November 1953, states that isoniazid is as effective as streptomycin in tuberculosis, at least in the early months. However, prolonged treatment with isoniazid does not result in a maintenance of this improvement. In fact, after four or five months of treatment with isoniazid alone relapse after initial improvement is worse than when isoniazid is combined with streptomycin or PAS. These data come from studies conducted by the Veterans Administration, Army and Navy, as well as those carried out by the Public Health Service.

Another problem that must be considered in the chemotherapy of pulmonary tuberculosis is the development of resistant organisms. It has been shown¹ that resistance to isoniazid develops at a greater rate when that drug is used alone than when it is combined with either streptomycin or PAS. The clinical significance of isoniazid resistance has been discussed recently by Coates,² *et al.* They showed that after three or four months of treatment with isoniazid or iproniazid the emergence rate of resistant organisms becomes significant. In their patients, when resistance to isoniazid developed, the sputum contained tubercle bacilli in numbers greater than those recovered before treatment was begun.

Dubos³ has pointed out that although isoniazid can kill tubercle bacilli intracellularly in tissue culture, in an *in vivo* environment there may be substances present which inhibit these antimicrobial drugs. Areas of necrosis, particularly caseation necrosis, contain a variety of partially broken down tissue components of unknown chemical composition, many of which may act as drug inhibitors. Another aspect discussed by Dr. Dubos is the question of whether bacillary forms which are seen in resected lesions but which fail to grow in culture media are actually dead. The possibility exists that

these organisms are viable and may prove of danger to the patient in the future unless their source is removed.

Finally, Auerbach, Katz and Small⁴ have demonstrated that following chemotherapy there is epithelialization of the bronchocavitary junction which prevents complete closure and inspissation of tuberculous cavities. This, if confirmed, must be considered an undesirable side effect of the chemical treatment of pulmonary tuberculosis.

The work of Drs. Segal and Chakravarty is encouraging and stimulating. It suggests that in selected cases treatment with isoniazid or iproniazid alone is effective in managing pulmonary tuberculosis. However, even in their series, significant percentages of patients failed to convert their sputum from positive to negative and patients with cavities failed to show cavity closure or significant reduction in size. A great deal of further investigation and research is needed concerning the mode of action by which chemotherapy is effective in tuberculosis, the management of infection with resistant organisms, and in the evaluation of the exact place of anti-tuberculosis drugs in the over-all treatment of this disease. Thus far, at least, it can be said that no single drug has yet been found which can eradicate pulmonary tuberculosis once and for all.

1. Tucker, W. B.: A Review of the Current Status of the Chemotherapy of Tuberculosis. *Ann. of Int. Med.* 39:1045, November, 1953.

2. Coates, E. O., Jr., *et al.*: The Clinical Significance of the Emergence of Drug-Resistant Organisms During the Therapy of Chronic Pulmonary Tuberculosis with Hydrazides of Isonicotinic Acid. *New Eng. J. Med.* 248:1081, June 25, 1953.

3. Dubos, R. J.: Viability of Tubercle Bacilli *In Vivo* with and without Chemotherapy. *Am. Rev. Tuberc.* 67:874, June, 1953. (Abstracted in *Tuberculosis Abstracts*, J. M. Soc. N. J. 50: December, 1953).

4. Auerbach, O., Katz, H. L. and Small, M. J.: The Effect of Streptomycin Therapy on the Bronchocavitary Junction and its Relation to Cavity Healing. *Am. Rev. Tuberc.* 67:173, February, 1953.

HAROLD J. MUENDEL, M.D.[†]

Basking Ridge

Acute Surgical Abdomen*

Seven conditions responsible for ninety per cent of acute abdominal emergencies are discussed and important points in differentiation enumerated.

ACUTE abdominal disorders frequently present a diagnostic problem to the physician, who often must make a prompt bedside differentiation without benefit of elaborate laboratory studies. Among the fifty or more causes of "acute abdomen," seven are responsible for the majority of cases. Of these, five are intra-peritoneal; (1) acute appendicitis, (2) acute cholecystitis, (3) acute pancreatitis, (4) perforated peptic ulcer, (5) intestinal obstruction; one is extra-peritoneal—renal colic; and one is extra-abdominal—acute myocardial infarction.

An "acute abdomen" is one in which severe pains persist for as long as six hours, the patient previously having been fairly well. Morphine should not be used until there is some certainty in diagnosis because it only suppresses the symptoms, and does nothing to alter the intra-abdominal disease.

Certain items in the history are quite important. Idiopathic intussusception occurs most commonly in a child less than two years of age. Appendicitis seldom occurs in infancy, more often in young adolescents and adults. Obstruction of the large bowel by cancer rarely is seen before thirty, infrequently before forty, most

commonly after forty. Perforated peptic ulcer is very rare under fifteen. Cholecystitis and twisted ovarian pedicle may occur in childhood, but are more common in adult life. The exact time of onset is most important. Perforated ulcer and acute pancreatitis are the only two abdominal conditions which commonly make a man faint. In a male with severe abdominal pain, the first thought is acute appendicitis or perforated ulcer. In a female, think of an ectopic pregnancy that has ruptured. The location of the pain at its beginning, whether it shifts or localizes, how severe the radiation, and whether it is influenced by respiration, should be ascertained.

Vomiting, except when caused by too great an intake of alcohol or dietary indiscretion, may be due to one or more of three causes and can be explained physiologically as follows:

- 1) Severe irritation of the nerves of the peritoneum or mesentery, as in perforation of ulcer or of a gangrenous appendix, or torsion of an ovarian cyst pedicle.
- 2) Obstruction of the involuntary muscles, such as bile ducts, ureter, uterus, or intestine itself.
- 3) The action of absorbed toxins on the medullary center.

It is always important to question the individual about constipation and diarrhea, and in a female, inquire about the menstrual cycle.

* Published with permission of the Chief Medical Director, Department of Medicine and Surgery, Veterans Administration, who assumes no responsibility for the opinions expressed or conclusions drawn by the author.

† Chief, Surgical Service, Veterans Administration Hospital, Lyons, N. J.

It is also important to determine whether there have been other similar attacks, any previous operation, or what familial tendencies may be present.

IN THE examination of the patient the general appearance is very important. For instance, marked pallor, lividity and perspiration indicate the shock of acute perforated ulcer, acute pancreatitis, or acute strangulation of the intestine. Deathly pallor also suggests intra-abdominal hemorrhage, such as a ruptured ectopic pregnancy, or hemorrhage due to an accident. At times, however, a patient with perforated ulcer does not appear sick at all.

One must observe the attitude of the patient in bed. In ureteral colic, or gallbladder colic, the patient is extremely restless; this also occurs with myocardial infarction. With hemorrhage, the intra-abdominal cavity is quite immobile and when the legs are flexed tension of the psoas and recti muscles is relieved. This position is more comfortable for the patient.

The pulse is not a reliable index of intra-abdominal disease. One can have a perforated ulcer with either a rapid or slow pulse. The respiratory rate, however, is important in differentiating abdominal and thoracic conditions. In practically all surgical abdomens the temperature is near normal, or subnormal; sometimes twelve to twenty-four hours later it may rise to 100 degrees, especially in perforations of viscera. Occasionally, absorption of toxins may bring the temperature down to normal, or below. A subnormal, normal, or elevated temperature, may accompany acute abdomen, but in the presence of a high temperature think of the thorax and kidney. Inspecting the tongue is valuable. There is an old adage, "clean tongue and slow pulse speak of renal colic."

IN THE physical examination it must be stressed that all hernial orifices should be inspected and special attention directed to the femoral canal, particularly in obese, flabby individuals who may have a very small hernia which is easily overlooked. It is also important to notice respiratory movements of the abdominal wall.

Muscular rigidity is only a relative term. Some patients will present an abdomen that is very rigid, without much tension. Hyperesthesia almost always indicates visceral or parietal peritoneal irritation and is usually found below the umbilicus. It is always important to do manual or bimanual palpation of the loins to determine kidney infection. Iliopsoas rigidity is a reliable indication for determining the position of the diseased appendix. Iliopsoas rigidity is easily observed by having the patient lie on the left side and extending the right leg. If this provokes pain, the appendix rests on the fascia of the iliopsoas muscles. Shifting dullness is sometimes of value in demonstrating free fluid in the abdomen.

The pelvic examination is important. The rectal examination is also informative. Another important test for acute appendicitis is the obturator test. Have the patient lie on the bed and flex his leg; rotating or abducting the thigh stretches the obturator internus and provokes pain, indicating the appendix is in the pelvis. Incidentally, the iliopsoas and obturator signs only determine where the acutely inflamed appendix lies. Examination of the pupils and knee jerks is very important if one suspects that there is tabes dorsalis. Urinalysis is important. The other features of the examination should include blood pressure, x-ray of the abdomen, and listening for peristalsis, whether active, hyperactive, absent, or tinkling.

ACUTE APPENDICITIS

ACUTE appendicitis is seen most often in adults below the age of forty, especially males. Cholecystitis is more frequent in women over forty. One of the first things said by a person having an acute appendicitis is "something I ate gave me a belly-ache." Within the first 24 hours the pain in the abdomen migrates to the right lower quadrant. A simple rule is to ask two questions: "Where was the pain when it started?" and "Where does it hurt now?" The pain is at first generalized, later localizes to the right lower quadrant.

Anorexia is the most common symptom of appendicitis. There are three degrees of gastric disturbance, depending on the extensiveness of

the appendiceal inflammation: anorexia if mild, nausea if moderate, vomiting if severe. Diarrhea and chills are very uncommon; less than one per cent. Constipation is the rule. If there is fever in suspected cases of appendicitis, you may be sure there is perforation with peritoneal infection. (Children are an exception—they develop fever at the slightest provocation).

In acute appendicitis, both recti become rigid. If the right rectus is rigid and the left is not, you must suspect a tumor or abscess below the right rectus. To demonstrate, have the patient raise the leg, and both recti will become contracted—never the right rectus alone. Rectus rigidity is evidence of muscular defense. The iliopsoas and obturator tests will locate the diseased appendix, whether sub-peritoneal, retrocecal, or in the pelvic cavity.

If pressure is applied upward on the left side of the abdomen, in the area of the descending colon and sigmoid, intraluminal gas will be compressed via the transverse colon and press upon the cecum, causing pain. Furthermore, there is increased tenderness over McBurney's point. Rebound tenderness is another sign of tenderness.

ACUTE CHOLECYSTITIS

THERE is a belief that certain types of people are predisposed to certain types of disease. It has been shown that people who are "fat, fair, fertile, flatulent, flabby, female and forty" are inclined to have gallbladder disease. Pregnancy develops a physiologic hypercholesterolemia; some of the cholesterol deposits on the mucosa of the gallbladder forming little polyps which break off and become nuclei for stones. It may take fifteen or twenty years before these grow large enough to cause irritation or obstruction. In individuals suspected of cholecystitis, there is a definite history of previous aversion to specific foods, so-called "selective dyspepsia."

When a patient with cholecystitis complains of constant pain, the pathology is probably edema. Colicky pain indicates an obstruction. Pain in the gallbladder is usually in the right subcostal region, but may be referred to the stomach. The stomach responds in three dif-

ferent ways: pylorospasm, midgastric spasm, or cardiospasm. Pylorospasm may be confused with peptic ulcer. Midgastric spasm can be confused roentgenologically with carcinoma. Epigastric or substernal pain in cardiospasm, or pseudo-coronary pain, may suggest coronary disease.

IN GALLBLADDER disease there is referred pain and radiating pain. Referred pain is not to be confused with radiating pain. For instance, pain in the gallbladder area radiates along the seventh intercostal nerve, to the tip of the right scapula, or interscapular area. But if the gallbladder perforates with leakage into the peritoneal cavity in the area of the diaphragm, pain is referred along the phrenic nerve.

Gallbladder pain cannot radiate to the right shoulder; but referred pain, involving the phrenic nerve, is indicative of a gangrenous, or ruptured gallbladder, with biliary peritonitis.

Hyperesthesia is determined by picking up the abdominal skin and letting it drop. Hyperesthesia above the umbilicus suggests gallbladder disease, below it, acute appendicitis.

PERFORATED PEPTIC ULCER

PERFORATED peptic ulcer is rare in females. Patients with this condition will almost always have a previous history of ulcer, or hemorrhage, yet the onset may be perforation. If the patient takes soda once in a while, or has a little distress after eating, it does not necessarily mean he has an ulcer. But if this has been frequent, it may help in suggesting a perforated ulcer. In a perforated ulcer there is severe pain, doubling-up in nature, and it comes after eating, accompanied by profuse perspiration and shock. The classical picture of board-like rigidity of the abdomen and the shock syndrome stand out. Peritonitis also causes paralytic ileus, with absence of peristaltic waves, as determined by auscultation.

Another sign is pneumoperitoneum which can be determined by x-ray or by increased tympany in the upper quadrants beneath the diaphragm.

ACUTE PANCREATITIS

THIS appears in one or two forms, edematous or hemorrhagic. The edematous type usually improves without treatment in 48 hours. The hemorrhagic form produces fat necrosis and becomes progressively worse. The etiology is obscure. It is usually associated with common bile duct spasm, stones in the duct, swelling and stasis. Recent studies have suggested that a good many alcoholics have pancreatitis. It is more common in women because they are susceptible to gallbladder disease. It is rare in Negroes. The attack almost always follows the ingestion of a heavy meal. There is excruciating and sudden pain. The pain radiates downward like an inverted fan. A patient with acute pancreatitis will always sit up, or lie on his abdomen to relieve pressure; he is never on his back because of pressure of the intestine overlying the pancreas. If you have reason to suspect pancreatitis, ask the patient to lie on his back and he will promptly refuse. Vomiting occurs in pancreatitis as well as moderate distention. On physical examination the patient is in shock, cold and clammy, with a rapid, thready pulse. Local epigastric tenderness is almost always present, associated with local defense. There is board-like rigidity and tenderness between the xiphoid and umbilicus. Fifty per cent of patients are mildly jaundiced, but clinically it is difficult to find a patient jaundiced. This is explained by the fact that the common duct is compressed by the edematous head of the pancreas. One of the specific aids in diagnosing acute pancreatitis is the serum amylase determination, which is strikingly elevated.

INTESTINAL OBSTRUCTION

STRANGULATED hernia causes about fifty per cent of intestinal obstructions. The remainder are divided among intussusception (in children under two), carcinoma of the large bowel in individuals over forty, and obstruction of bands, volvulus, or adhesions in patients having opera-

tions for gangrenous appendix, gunshot wounds, etc. Intestinal obstruction caused by volvulus is usually in the sigmoid, the descending colon, or the mesentery. The general symptoms of intestinal obstruction are pain, shock, vomiting, inability to pass feces or gas, and a moderate to considerable amount of distention with tenderness and visible peristalsis. Plain x-ray of the abdomen is of great help.

RENAL COLIC

RENAL colic sometimes can make differentiation difficult. Renal colic may be caused by a stone, a small clot, or debris, also a calculus of the kidney blocked on its way to the bladder or kinking at the ureteropelvic junction. It is most common in males. There is often a previous history of calculi, or there may be a history of gout or parathyroid disease. Paraplegics are particularly prone to renal calculi. Pain in the lumbar region radiates down the inner aspect of the thigh. The patient is exceedingly restless; there is vomiting on a reflex basis. There is frequency of urination, sometimes dysuria. The pain may disappear, which is quite important. Strangely enough, patients with renal colic have bradycardia. Most important is tenderness in the area of the twelfth rib, with hyperesthesia in this area. An x-ray may reveal stone, but it is perfectly safe to do an intravenous pyelogram.

CORONARY OCCLUSION

THIS occurs most often in individuals over forty and there is frequently radiation to the epigastrium, but it does not localize and that is an important differential point. There may be a pericardial friction rub, rales in the lungs, evidence of cardiac failure. The electrocardiogram is often diagnostic.

If these major conditions can be distinguished, ninety per cent of acute surgical abdomens will be diagnosed.

Madisonville Road

JACOB SEGAL, M.D.[†]

Browns Mills

SUSHIL CHANDRA CHAKRAVARTY, M.D.[‡]

Calcutta, India

Isoniazid and Iproniazid in Tuberculosis*

Isoniazid and iproniazid have been used as the only form of chemotherapy in a group of 89 patients. The encouraging results obtained indicate that each of these compounds by itself is potent against tuberculosis.

ISONICOTINIC acid hydrazide (isoniazid) is a chemically pure, synthetic substance of the general formula, $C_6H_7N_3O$. It is obtained in almost colorless crystals which are highly soluble in water. A closely related compound is the isopropyl derivative (iproniazid). Isonicotinic acid hydrazide is also related to pyrazinamide and amithiozone. Recent interest in these drugs developed following articles by Grunberg and Leiwant¹ and Grunberg and Schnitzer² in which they reported beneficial effects in experimental tuberculosis in mice.

Stimulated by these results, Selikoff, Robitzek and Ornstein³ investigated these preparations in human tuberculosis at Sea View Hospital. The first official communication was a preliminary report published in *The Quarterly Bulletin of Sea View Hospital* in January, 1952. Because of the limited circulation of this publication, news of this work had not spread very far or very fast within the profession. Most of us learned, therefore, of this new tuberculosis "cure" when we read in the public

press extravagant claims for Rimifon® and Marsilid®. This premature and exaggerated news was disconcerting. Tuberculosis workers throughout the country felt the immediate need for an official appraisal from authoritative investigators. Accordingly, meetings were arranged where hastily collected data were presented to the profession. The material was, understandably, inconclusive. Rather, one sensed from the honest enthusiasm of the exponents that there was more to these new drugs than the material presented actually revealed.

MATERIAL AND METHODS

SINCE March 1952, we have used these drugs on more than 100 patients. However, our present study concerns 65 patients treated with isoniazid and 24 with iproniazid. Thirteen of the latter had previously been treated with isoniazid.

The first patients treated were four with far advanced bilateral tuberculosis in the terminal stage. Naturally, we did not expect any spectacular reversal of their plight. We administered the drug merely to see whether it

* Presented before the Section on Medicine at the Annual Meeting of The Medical Society of New Jersey in Atlantic City on May 20, 1953.

[†] Medical Director, Deborah Sanatorium.

[‡] Formerly clinical fellow, Deborah Sanatorium.

would have any ameliorating influence on their agonal symptoms. No effect, however, could be discerned. These patients continued inexorably to a fatal end within three months. They have not been included in the present analysis.

The second group consisted of three female patients, all of whom had far advanced chronic pulmonary tuberculosis of five to six years' duration. All of them showed evidence of progressive decline within the previous year. They were first given a course of isoniazid, but because the effects seemed too slow to meet the urgency of their needs, we changed to iproniazid. From the first week of iproniazid treatment they all exhibited a sense of well being, diminution of their cough and expectoration and improved appetite. All gained weight rapidly, cough was reduced to a minimum, sputum output became scanty and they generally presented features which left no doubt as to the beneficial effect of the new drugs. In short, these three patients, who according to former standards would have been considered terminal, were improved beyond doubt by iproniazid.

Next we administered these drugs to patients with chronic cavitory disease. We did not expect an appreciable change in the cavities, but we did observe considerable absorption of the reversible pathology surrounding the cavities. Almost all these patients reported a sense of well being and improvement in symptoms.

We subsequently included in our experiment a considerable number of patients who had apparently recovered from their illness but whose sputa still contained tubercle bacilli as indicated by positive gastric cultures. These patients were asymptomatic and physical findings were negative. Their chest roentgenograms did not present any shadows indicative of residual pathology in the parenchyma. Bronchoscopy, with a few exceptions, did not reveal any pathologic changes in the main bronchi.

All these patients had had definite parenchymal lesions which had been resolved by bed rest, antibiotics, and minor or major surgical procedures before isoniazid therapy had been initiated. These patients all had their sputum converted a short time after treatment was begun. The sputum remained negative throughout

the course of treatment and for three months after cessation of the drug; in all seven to ten months of consistently negative sputa.

Finally, we administered isoniazid to patients in the following categories:

- 1. Those with recent spreads
- 2. Those with acute exudative lesions
- 3. Surgical patients to prevent postoperative spread.

The tables which follow indicate patient data and the results of treatment.

TABLE 1. PATIENT DATA (ISONIAZID)

A. Clinical Findings			
AGE GROUP	MALE	FEMALE	TOTAL
15 - 25	6	1	7
26 - 50	16	22	38
51 and over	17	3	20
	—	—	—
TOTAL	39	26	65

Number of Patients	
Duration of Tuberculosis (in years)	
Less than 1	10
1 to 2	11
2 to 5	20
5 and over	24
Extent of Disease	
Minimal	3
Moderately advanced	31
Far advanced	31
Former Procedures	
Streptomycin—PAS	47
Pneumothorax	18
Pneumoperitoneum	14
Thoracoplasty	17
Resection	13
Symptoms	
Fever	8
Cough and expectoration	32
Loss of appetite	26
Shortness of breath	11
Hemoptysis	10

B. Laboratory Data	
Number of Patients	
Sputum	
Positive	49 (75%)
Negative	16 (25%)
Hemoglobin (in percentages)	
Below 80	31 (48%)
Over 80	34 (52%)
Complications	
Endobronchial lesions	7
Tuberculous laryngitis	1

TABLE 2. EFFECTS OF ISONIAZID

A. Clinical Findings

	Number of Patients	Male	Female
Duration of Treatment			
3 to 6 months	44		
Over 6 months	21		
Symptoms After Treatment			
Fever	5		
Cough and expectoration	14		
Shortness of breath	2		
Hemoptysis	2		
Sense of well being	59		
Weight Gains			
No gain	19	15	4
1 to 10 lbs.	32	16	16
11 to 20 lbs.	11	6	5
21 to 30 lbs.	1	1	0
31 lbs. and over	2	1	1

B. X-ray and Laboratory Findings

	Number of Patients	
X-ray Findings		
No change	31 (48%)	
Absorption of exudation	32 (49%)	
Shrinkage of cavity	2 (3%)	
Laboratory Findings		
Sputum		
Positive	24 (37%)	
Negative	41 (63%)	
Hemoglobin (in percentages)		
Below 80	23 (35%)	
Over 80	42 (65%)	
Complications		
Endobronchial lesions	3	
Tuberculous laryngitis	0	

TABLE 3. PATIENT DATA (IPRONIAZID)

A. Clinical Findings

AGE GROUP	MALE	FEMALE	TOTAL
15 - 25	2	0	2
26 - 50	5	10	15
51 and over	6	1	7
TOTAL	13	11	24

Number of Patients

Duration of Tuberculosis (in years)	
Less than 1	1
1 to 2	4
2 to 5	9
5 and over	10
Extent of Disease	
Minimal	2
Moderately advanced	8
Far advanced	14
Former Procedures	
Streptomycin—PAS	23

Pneumothorax	10
Pneumoperitoneum	5
Thoracoplasty	17
Resection	7
Isoniazid	13

Symptoms

Fever	3
Cough and expectoration	15
Loss of appetite	10
Shortness of breath	4
Hemoptysis	3

B. Laboratory Data

	Number of Patients	
Sputum		
Positive	15 (62½%)	
Negative	9 (37½%)	
Hemoglobin (in percentages)		
Below 80	16 (67%)	
Over 80	8 (33%)	
Complications		
Endobronchial lesions	6	
Tuberculous laryngitis	1	

TABLE 4. EFFECTS OF IPRONIAZID

A. Clinical Findings

	Number of Patients	Male	Female
Duration of Treatment			
3 to 6 months	20		
Over 6 months	4		
Symptoms after treatment			
Fever	1		
Cough and expectoration	10		
Shortness of breath	1		
Hemoptysis	0		
Sense of well being	24		
Weight Gains			
No gain	4	2	2
1 to 10 lbs.	6	3	3
11 to 20 lbs.	10	6	4
21 to 30 lbs.	2	2	0
31 lbs. and over	2	0	2

B. X-ray and Laboratory Findings

	Number of Patients	
X-ray Findings		
No change	10 (42%)	
Absorption of exudation	13 (54%)	
Shrinkage of cavity	1 (4%)	
Laboratory Findings		
Sputum		
Positive	11 (46%)	
Negative	13 (54%)	
Hemoglobin (in percentages)		
Below 80	16 (67%)	
Over 80	8 (33%)	
Complications		
Endobronchial lesions	1	
Tuberculous laryngitis	0	

C. Side Effects (24 patients)

	Number of Patients
Headache	6
Vertigo	17
Tinnitus	6
Hyper-reflexia	19
Drowsiness	8
Insomnia	6
Disturbed vision	10
Nightmares	10
Constipation	14
Delay in starting stream	4
Polyuria	2
Weakness of legs	13
Dryness of mouth and upper air passages	13
Allergic reaction	
Skin rashes	8
Urticaria and angio- neurotic edema	2

Three examples of appreciable x-ray changes following isoniazid and iproniazid are presented. Figure 1a shows a large cavity in the right apex. This had remained stationary for some months on bed rest. Figure 1b shows no change after three months of isoniazid, but following three months of iproniazid there is considerable shrinking of the cavity (figure 1c).

The second case is presented in some detail to illustrate the potential efficacy of isoniazid when used alone.

CASE REPORT

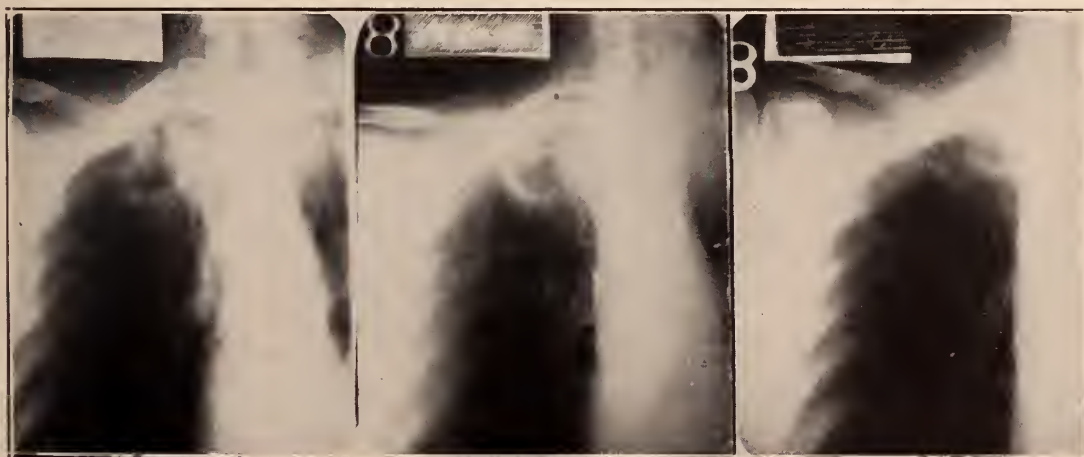
A. Z., a 47-year old female, was admitted to Deborah Sanatorium in April, 1952. On admission

she was pale, haggard and dyspneic. Her height was 5 feet, 4 inches; weight, 99 pounds. Figure 2a, taken on admission, shows a pneumoperitoneum. Overlying the right diaphragm there is a soft nodular confluent infiltrate involving the entire right lung field; also a few annular shadows in the apex. The left upper lobe shows a giant cavity with diffuse dense mottling in the lower half. The patient expectorated large amounts of sputum which contained tubercle bacilli in abundance. Her temperature ranged from 99 to 100 degrees daily. She was also found to have diabetes which was untreated prior to admission.

Treatment consisted of abandoning the pneumoperitoneum, absolute bed rest, and insulin for the diabetes. A course of isoniazid was started. By the second week of chemotherapy the temperature returned to normal, her appetite increased, and she began to gain weight. Her cough and expectoration diminished. By January 1953, she had only a few symptoms, had gained 30 pounds and her chest x-ray (figure 2b) showed considerable absorption of the infiltrate in both lung fields. The cavities in both upper lobes, however, remained unchanged.

In January 1953, a left upper lobectomy and thoracoplasty were performed. Figure 2c shows her post-operative status: the left lower lobe has expanded and is free of active lesions. The right lung still contains a cavity in the apex.

Figure 3a is the film of a patient who was admitted in August, 1952 with high fever, cough, expectoration, hemoptysis, and extreme weakness. He appeared emaciated and anemic. His sputum was positive for acid fast bacilli. Figure 3b shows the striking improvement which followed eight months of isoniazid.

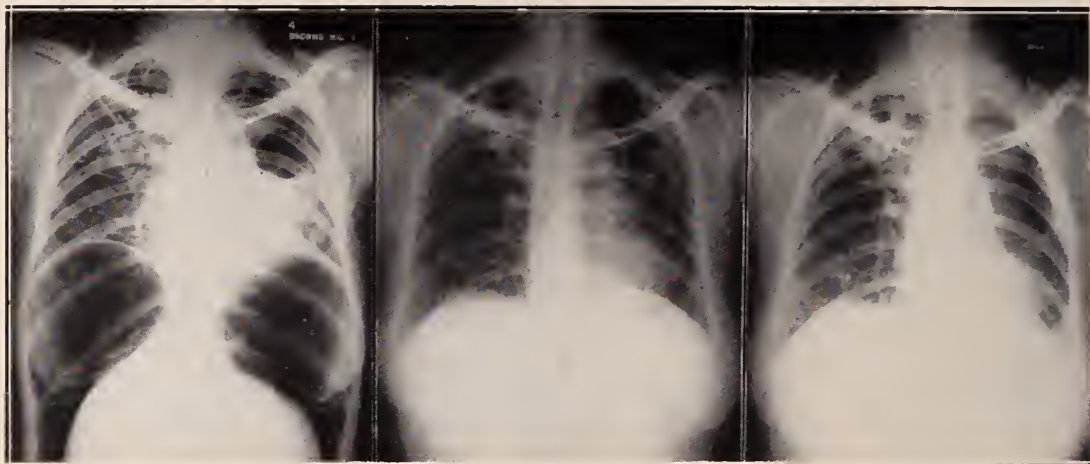


a.

b.

c.

Figure 1 (tomograms). a. June, 1952. Three months of conservative treatment. No change noted. b. September, 1952. Three months following isoniazid therapy. c. January, 1953. After four months of iproniazid.

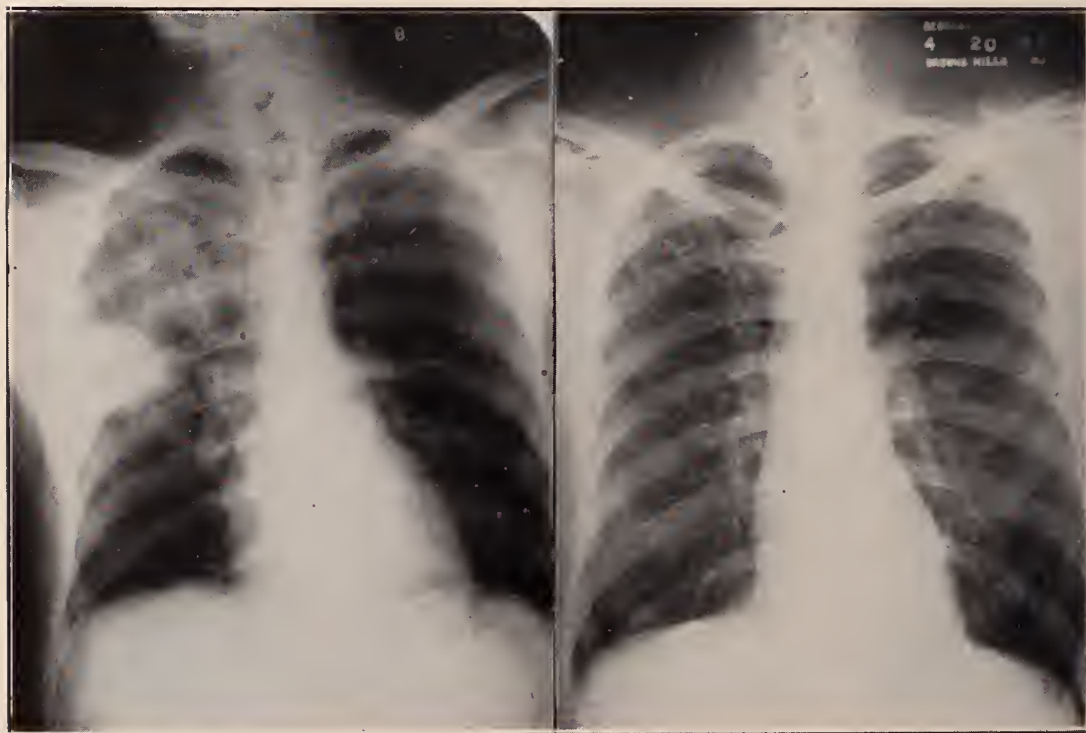


a.

b.

c.

Figure 2. a. April, 1952. Admission. b. December, 1952. After six months of isoniazid therapy. c. April, 1953. Four months after left upper lobectomy.



a.

b.

Figure 3. a. August, 1952. Acute right upper lobe tuberculous pneumonia. b. April, 1953. After eight months of isoniazid.

DOSAGE

WHEN this investigation was begun the accepted dosage of these drugs was 2 to 4 milligrams per kilogram body weight. In our series an average dose of 3 milligrams per kilogram was used. It is now felt, however, that 8 to 10 milligrams per kilogram of isoniazid is optimal and will not produce prohibitive side effects.

RESULTS WITH ISONIAZID

SIXTY-FIVE patients were treated with isoniazid for periods of three to nine months. All these patients experienced a sense of well being, unparalleled to that obtained from any previous treatment.

Fever was reduced in 37 per cent. Cough and expectoration were decreased or disappeared in 57 per cent. Tendency toward hemoptysis diminished in 80 per cent. Only 20 per cent of patients who complained of shortness of breath before treatment continued to do so afterwards. All patients showed marked improvement in appetite and weight.

Fifty-one per cent of the patients have had their sputum converted from positive to negative, and 52 per cent showed appreciable regressive changes in their chest x-rays.

RESULTS WITH IPRONIAZID

ALMOST all patients taking iproniazid seemed to exhibit euphoria from the first week of treatment. In this group fever was reduced 67 per cent, cough and expectoration 34 per cent, hemoptysis 67 per cent, and dyspnea 75

per cent. All patients showed an improvement in appetite and weight.

In the iproniazid group there was a 25 per cent sputum conversion rate and 58 per cent of the patients showed significant improvement in their chest x-rays.

TOXICITY

IN THIS series isoniazid caused very few mild and fleeting side effects. On the other hand, iproniazid at the same dose level produced severe side effects, but these disappeared after the drug was withdrawn. (See Table 4.)

DISCUSSION

THE results of this study indicate that isoniazid and its isopropyl derivative are potent anti-tuberculosis agents. It is important to emphasize that in this study these drugs were used alone. The majority of investigations, including that carried out by the Veterans Administration, are evaluating the use of these drugs in combination with streptomycin and P.A.S.

Our studies indicate that when used alone these two preparations produce striking clinical improvement in selected patients. They also have a decided effect on the exudative phase of the disease. With their use the general condition of many patients can be improved to the point where definitive collapse or surgical therapy, previously contra-indicated, may now be used.

Acknowledgment: We are indebted to Schering Corporation, E. R. Squibb & Sons, Organon Inc., and Nepera Chemical Co., Inc. for the supply of isoniazid, and to Hoffmann-La Roche Inc. for supplying us with Rimifon® and Marsilid®.

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MARTIN GUMPERT, M.D.

New York

Geriatrics---A Social Problem

The increasing importance of the aged in our population dictates the need for a fresh approach to their problems. Newer concepts of the pathology and physiology of aging and special consideration of the mental changes are outlined.

EVERY aged person is given four choices for his conduct of life: 1. Continuation in gainful occupation, 2. leisure, 3. idleness, 4. recreation.

The persistence of gainful occupation means the prolongation of middle-age activities into old age. Many people are willing and able or forced by economic necessity to maintain employment far beyond the customary or official age of retirement. This point of retirement has, at least in theory, changed in recent years from a rigid chronologic time (fixed at age sixty or sixty-five) to a fluctuating date measured by the physical and mental capacities of the individual for the work he is expected to perform.

We all are convinced that our compulsory retirement limits—which are still accepted by the majority of employers—are old-fashioned because of our changed standards of health and human life expectancy. They are the cause of tremendous economic waste, they destroy the consumer capacity of a steadily growing segment of our population, and they cause an increasing burden on public welfare. They are also grossly unjust and physically and emotionally deleterious to the prematurely retired individual. We ought to acknowledge that the word “retirement” is a technical term applicable to labor relations but that it does not de-

serve to persist as an ideologic concept. Retirement from life is impossible as long as life persists.

Leisure is another concept which is today badly abused. Leisure can only co-exist with work as its physical counterpart. Work often produces a state of tension; leisure characterizes the release from work tension, the necessary relaxation which, in the rhythmic flow of life, precedes and prepares the return to new work.

Leisure is devoted to the rather strenuous play of imagination and free association and to the recuperation from stress, to the regaining of balance. Undirected leisure which does not result in new effort will soon degenerate into idleness. Idleness is the physical breakdown from too much leisure and is equivalent to a physical breakdown from overwork. That old age be a period of prolonged, enforced (so-called “well-deserved”) leisure is a slogan which plays havoc with millions of lives. Leisure as a constructive recharging of energies is a most important retreat for the older person. It is more needed than in younger years because the energy reserves of old people have decreased and strong efforts can only be accomplished by prolonged intervals of rest. However, it is wrong to believe that old people want more leisure and it is evident that nothing is

* Delivered during the Workshop on Employment of the Physically Handicapped held at the Kessler Institute for Rehabilitation on October 2, 1953, under the sponsorship of the Advisory Committee on Rehabilitation of The Medical Society of New Jersey.

more injurious to their facilities than an over-dosage of leisure.

The faculty for leisure decreases in old age together with the corresponding faculty for work. Young people can indulge in a hilarious waste of their leisure time, and they do; their whole organism requires an excess of spending. Old people, however, have to measure their expenditures in all directions; as our days grow longer and our pace slows down, time contracts and becomes our most precious possession. Therefore, the older person reacts with a feeling of breathless hurry, facing the inevitable deadline of his existence and still wanting to accomplish many unfinished jobs.

WE KNOW that death is with us and within us from the first day of life and that on the partial dying of our organism and the regeneration of damaged substance depends the continuation of our lifespan. Indeed, we are, consciously or not, deeply involved in this violent struggle of defense against the advances of death, and the power of recreation is our most vital weapon. I have on several occasions defined aging as a process in which we do more and more things for the last time and less and less for the first time. This explanation of the dynamic quality of aging offers its most promising therapeutic approach: to try to reverse this movement by doing—in the course of aging—more things for the first time and by trying to avoid “last appearances” in whatever pursuit we follow. Such technic might well be called “recreation” and the best moment for its exercise is when old age begins.

MOST of us reach this milestone in a depleted and exhausted condition. A disintegrated old age has its roots, mentally and physically, in a mismanaged middle age. Middle age is the period in which the chronic degenerative diseases have their hidden onset. Even more important, middle age is the time of intellectual and emotional shrinkage and deterioration, of a steadily narrowing horizon, of resignation and limitation. If anything, old age—if not unduly endangered by disease—is a time of recuperation, of the powerful stimulation of early

wishes and wants which have long been forgotten at the assembly line of middle age. This genuine creative flare-up of vitality in many old people frequently breaks through the rigid crust of middle life and is a phenomenon which should be seriously considered in work with older people.

There are, of course, specific characteristics which make old age different from other periods of life. These differences extend to the pathology of the older person as well as to his normal state. In the field of pathology we recognize how extremely difficult it is to separate genuine organic changes from their secondary environmental factors. The image of old age is darkened by the traditional misconceptions and prejudices of centuries. What appears to us inevitable decline is often nothing but our conviction that that is what old people are like and what they themselves expect to be like; a biased opinion which dissolves before an open-minded and active, optimistic approach. We have, in recent years, discarded prejudices concerning the physical endurance of older people and have changed our mind concerning the mental disorders of old age. The whole concept of senile dementia as a hopeless disintegration has been thoroughly revised. The existence of senile neurosis, so long denied and neglected by psychoanalysis, is now admitted and more thoroughly explored. The specific sensitivities of older people in regard to drugs, their specific nutritional requirements, the lack of response of their vegetative functions have been better studied. Arteriosclerosis is no longer considered a part of the process of aging but as a pathologic entity, the biochemical background of which is increasingly understood. Degenerative heart disease is now evaluated with greater accuracy and treated by a variety of active measures. Loss of hearing and eyesight, which contributes so much to the unhappiness and isolation of old people, can be assisted by new and ingenious devices.

BUT all this is not enough. We may look forward to a future in which most of the distressing health problems of old age will be solved and the fear of old age as a time of inescap-

able physical and mental decay banished. However, there could be thousands of geriatricians and the life expectancy could be prolonged for another ten or twenty years, yet it still might take our civilization a hundred years to make the necessary intellectual and social adaptation to the changing structure of society. The appearance of an industrial working class in the nineteenth century brought about revolutions, world wars and conflicts which have shaken the earth and still continue to do so. At the end of this century we shall have in this country 25,000,000 people over the age of sixty-five, yet only a few of our generation are aware of the tremendous implications for our civilization. This unprecedented evolution of the aged from an isolated, poorly understood group into a mass sector of millions requires a thorough re-examination of all of our social and cultural values. It is not only the aged who have to adapt themselves to their newly won importance but, far more so, society as a whole which must adapt to the multitude of the aged. There can be no doubt that the whole quality of life will change profoundly simply by the weight of their presence.

I WOULD say that our present experiences with old people are quite inconclusive because the average old person as we know him today is not a normal specimen but the result of many years of frustration and mismanagement. The face of old age will change rapidly and radically in years to come and what we consider today to be an inherent characteristic of aging may soon be revealed as nothing of the sort, but a disability resulting from entirely different influences.

Especially do some of our testing devices deserve, in my opinion, severe criticism. We are, as a nation, addicted to tests in medicine as well as in the assessment of other efficiencies or deficiencies. Sometimes it seems that we prefer bad tests to no tests. It cannot be denied that one of our greatest problems in geriatrics is the accurate determination of biologic age in contrast to chronologic age because we know that the latter is not a fair measure of an older person's capacity. Most of the tests, however,

which are at our disposal today are childish, untrustworthy and completely unrealistic. Not only do they fail by applying the same yardsticks to young and to old people; they are completely inept in measuring the influence of age on a person's personality, on his intellectual and emotional capacities, and they give not the slightest insight into the most essential quality of an old person—his vitality. All of these tests, even the sane ones, have so far overlooked the fact that an old person lives under an entirely different concept of time than a younger person and that this difference of time has no relation to his intelligence or physical capacity. Still, most tests are based on stereotyped measures of time, such as solving a problem within a certain number of minutes, or—what is even worse—on superficial assessments of memory function or of physical strength, endurance and swiftness. None of these factors can be of any use in the judgment of old age capacities. Memory, it is agreed, is frequently impaired in advanced age, especially the retention of names or recent events. But there are many kinds of memory; there are, furthermore, many activities for which a perfect memory is not needed. Physical strength is also no accurate measure if the job to be done does not depend on strength and endurance. Slowness, again, has its advantages as well as its disadvantages and there can be no doubt that quickness is far overrated in our society.

THE aged are charged with various mental limitations: their intellect is said to suffer from a gradual narrowing of interest. The aged person becomes egotistic and isolated; the differentiation between essentials and non-essentials is lost: bowel movements have more importance than questions of war and peace; new ideas and new devices are adopted with difficulty and rarely created. But these difficulties are not different in principle from those of adult life; they are only more pronounced. Neurotic trends are intensified in old age but so are personality assets. The feeble-mindedness of the aged is most often only a continuation and intensification of the feeble-minded-

ness of the average adult. When suffering from chronic and violent physical disturbances or when tortured by the feeling of economic insecurity most people of any age give up their objective interests. On the other hand, people who have led active intellectual lives in adolescence and maturity continue to do so in senescence. Indeed, reasoning power and objectivity are often strengthened in older persons. The limited capacity for new ideas is not always what it seems, but is frequently a neurotic defense against the aggressiveness of the younger generation.

IT IS true, however, that the emotions often become highly sensitized in later years. In contrast to popular opinion, the acuity of emotional response seems to be stimulated by aging. Our emotional structure does not age or at least only very slowly. Abnormal irritability, stubbornness or sullen resignation are often found, sometimes alternating without obvious motivation. Many elderly people are emotionally unstable, breaking into tears or laughter on slight provocation. They are frightened and suspicious, and this tendency may grow into a persecution complex and even produce suicide or acts of violence toward others. They are frequently stingy and collect all kinds of worthless material from which they refuse to part. Their sense of veracity is often impaired and they use lies and fantasies as substitutes for lost money or as disguises for their inadequacy. They stimulate or dissimulate physical disturbances. They sometimes develop a kind of infantile sexuality because of their inhibited sexual outlets. Carelessness of appearance, untidiness and deterioration of manners are not uncommon.

In some cases their will power is increased to senseless obstinacy while others can be too easily influenced and molded. They become easy prey for fakers, or victims of criminals since their tendency to self-pity, their loneliness and desire for affection can easily be exploited. They are grateful and suspicious at the same time and their feeling of insecurity is great, even when hidden behind a mask of self-assurance and conceit.

IF WE look at this array of symptoms, forgetting the age of the patient, they are not much different from the state of mind of a problem child or a maladjusted adolescent. We ought to be cautious in diagnosing them as senile. Social maladjustment will produce these disorders at any stage of life. Change of attitude on the part of the patient and the people around him will result in far-reaching improvement. A planned recreational program will have a surprising psychotherapeutic effect.

There are, of course, mental changes that are primarily age symptoms and are not dependent on environmental causes. But even these are far more accessible to treatment than has been assumed up to now. The brain of the aging person behaves in the same way as his heart. Its normal achievements may be well balanced and above the average level. But even a slight degree of exertion can develop into a picture of major disease.

Therefore an aged brain may be in perfect working condition under a regime of emotional stability, sufficient rest and good nutrition. But its achievements are limited in length of time and its energies should never be overtaxed. After a period of brilliant activity, the mind of an elderly person fades easily into a dimout of fatigue. This may lead to confusion, lack of orientation, and poor mental organization in discussion, with a tendency to overtalk or to change the subject abruptly. Such signs of fatigue are usually noted by the person himself and should be explained to him. Increased fatigue can be overcome only by increased rest.

MENTAL and emotional peculiarities are often connected with physical disease. We know the tempers and moods of the patient who suffers from chronic digestive disease, the instability of the diabetic, the anxiety of the cardiac patient, the depression of the arteriosclerotic. Every chronic disease is mirrored in a corresponding emotional condition and since elderly persons often suffer not only from one but several chronic ailments, their mental state exhibits a variety of abnormal reactions which may be well improved by treating the under-

lying cause, but which are often simply dismissed as senile.

Since fatigue and weakness are general and common symptoms of the aging process, it is often forgotten that they are also signs of organic disease. One should never take abnormal fatigue for granted in an elderly person. In later years the mental reaction to drugs, to toxic conditions, to nutritional deficiencies becomes stronger. The sedatives and sleeping drugs, laxatives and cough medicines that fill the medicine chest of the average elderly person are prescribed much too often and in too great quantities and strengths. Many states of confusion and depression and weakness are cured if medicine is taken away.

Allergic conditions are likewise very apt to result in mental reactions that are falsely taken to be signs of senile debility. Metabolic disturbances can become the cause of drastic mental changes. Chronic constipation, gallbladder or prostatic disease influence the state of mind. Fatigue and somnolence may result from intoxication caused by diseased kidneys. Such states, some of which can be efficiently treated, are often not recognized and are mistaken for mental senility.

NUTRITIONAL deficiencies may also play an important part. Many old people live on reduced and monotonous diets which are lacking in some of the essential vitamins and minerals. Mental debility in old age is often a symptom of vitamin deficiency, for instance of a hidden pellagra, and can be miraculously improved by changes in diet if its real nature is recognized early enough.

As we see, this dreaded symptom of mental decline in later years should never be received

with resignation; on the contrary, it should provide a strong impulse to discover what is wrong with the patient as there are broad opportunities for successful treatment. Feeble-mindedness and healthy old age never go together.

Comprehension, reasoning power and judgment are the result of long exercise. An understanding of one's abilities and limitations comes too late for many, but it forms a driving force for the achievements of a successful old age.

If we insist that most of the pathologic conditions customarily identified with old age be strictly separated from the process of aging as such, we want to emphasize at the same time that it is not normal for an old person to be in perfect health. In fact, nobody reaches advanced age without the challenge of illness. In my experiences with a group of very old people between the ages of 78 and 95 who have maintained their social prestige and their creative capabilities I found that almost all of them had suffered for long periods of time from a variety of chronic illnesses.

WE HAVE not given enough attention to the utilization of our vital forces because medicine and perhaps society as a whole is addicted to deficiency-finding instead of ability-defining. People of advanced age, wherever we meet them, are living examples of high-powered vitality and endurance; otherwise they would no longer be alive. In future geriatric research we should concentrate more on what keeps these people alive than on what makes people die. Old people are experienced and proved survivors. This extraordinary quality of survival which has very little to do with their actual state of health is the great geriatric secret we have to uncover.

728 Park Avenue

FRED B. ROGERS, M.D.

Trenton

Abraham Coles, Poet-Physician of New Jersey

This biographic sketch of one of New Jersey's outstanding physician-poets of the nineteenth century presents interesting information concerning the cultural history of our state.

AN INTERESTING group of physicians are the medical poets and litterateurs, men who have made notable contributions to literature. Their writings often reveal, as Sir William Osler said, that they "recognize the true poetry of life". Hippocrates, Rabelais, Goldsmith, Keats, Schiller, Holmes, Conan Doyle, Ronald Ross, Robert Bridges and others have contributed not only to medicine but also to the world's store of belles-lettres. At present, A. J. Cronin, W. Somerset Maugham and Albert Schweitzer need no introduction as authors, although readers are seldom familiar with their medical backgrounds. In our own state, Dr. William Carlos Williams, a practicing physician of Rutherford, ranks high among contemporary poets. The sparetime activities of medical men often have developed into second careers, which, in some instances have been so noteworthy that their medical connections have almost been forgotten.

During the nineteenth century, New Jersey contributed an outstanding poet-physician to this group of authors. Dr. Abraham Coles, centennial president of The Medical Society of New Jersey, was well known in his day as a poet, hymnist and classical scholar, in addition to his reputation as a philanthropist

and medical practitioner. Dr Coles lived in a less specialized era than today—one in which physicians displayed wide interests in cultural, literary and civic affairs. Unlike some other medical men of letters, however, he did not forsake medicine on acquiring literary fame. Each of the several aspects of this remarkable man's career (physician, poet, hymnist, classicist, philanthropist) may be profitably studied. His life and works still serve as a source of inspiration to the medical profession.

Born at Scotch Plains on December 26, 1813, Abraham Coles received a thorough classical education. At the age of seventeen he was teaching Latin and mathematics in the Bond Academy of Plainfield—a position which he left to study law before deciding upon medicine as his life work. After attending lectures at the College of Physicians and Surgeons in New York, he completed the medical course at Jefferson Medical College, Philadelphia, receiving a medical degree in 1835. (A classmate and close friend at Jefferson was the famous gynecologist, J. Marion Sims of South Carolina). Coles' doctoral thesis had as its subject, "The Human Frame . . . as exhibiting the Wisdom of the Deity". A devout student of the Bible, he always associated medi-

cine and religion, and regarded his own profession as a sacred one.

The year after graduation, Dr. Coles settled in Newark, where he established a solid reputation as a skillful practitioner. In addition to an extensive practice he was soon writing and participating in civic projects during his spare hours. Married in 1842 to Caroline Ackerman of New Brunswick who died five years later, Dr. Coles was the father of two children, Jonathan Ackerman Coles (who became a well known surgeon), and Emilie S. Coles (later a woman of considerable literary ability).

IN 1848 Abraham Coles travelled to Europe for further medical study. He was in Paris during the revolution of that year and had an opportunity to gain much surgical experience in the French hospitals. The eventual failure of this republican uprising and subsequent continued European turmoil during the next quarter century were later the subject of correspondence published by Dr. Coles in the *Newark Daily Advertiser*. At the time of the Franco-Prussian War, his report, "Paris in 1848 and 1871—A Personal Experience", reviewed the struggles of that period and commented forcefully on the futility of war. Again in 1854 he returned to Europe, this time with the aim of studying modern languages. His poem, "Windermere", and an essay, "Rome, Italy—February 1854", tell of travels through England and the Continent during this second visit. Within his seventeen month stay Coles met many distinguished persons including the Brownings.

After returning from abroad, Dr. Coles assumed responsible positions in The Medical Society of New Jersey, being elected the seventy-second president of this organization during the hundredth year of its existence. Following the initial publication of his writings in 1847, his output as an author became voluminous and erudite, encompassing both medical and cultural subjects. In recognition of his literary and scientific achievements, Rutgers College conferred an honorary A.M. degree upon Dr. Coles, Lewisburg University (Bucknell) a Ph.D. in 1860, and Princeton an L.L.D. in 1871.

COLES' ancestral home at Scotch Plains, "Deerhurst," extended warm hospitality to many distinguished visitors during his lifetime. In the beautiful gardens surrounding his estate, Dr. Coles had constructed a facsimile of the famous Hampton Court Labyrinth after the original hedgemaze near London. He also kept a herd of deer on the lawns about his home for the entertainment of his guests. His friend, Oliver Wendell Holmes, wrote: "I have always considered it a great privilege to enjoy the friendship of so pure and lofty a spirit; a man who seemed to breathe holiness as his native atmosphere, and to carry its influence into his daily life".

Abraham Coles died on May 3, 1891, at Monterey, California, while on a trip to recover health which had been undermined by an attack of influenza earlier that year. A Memorial Tribute in the *Transactions of The Medical Society of New Jersey* (by Dr. Ezra M. Hunt, a former office associate and president of the Society just before its Centennial), said of him: "Such lives do not die, but live as incentives for those of all the ages. We cannot reach his fame, but we can imitate his . . . humble affection for the good, the beautiful, the true".

FROM the time his medical license was recorded in 1836, Coles' name appeared often in the *Transactions of The Medical Society of New Jersey*: in 1840 as a delegate of Essex County to the Society's meetings; and ten years later as a Censor (Medical Examiner) for that county. During the following year (1851) he was one of three members appointed as a committee "to investigate the effects of blood-letting upon the vital organs". Likewise the next year found him on a delegation directed to report on establishing a medical library for the Society. A varied professional experience during these years was indicated by mention of Dr. Coles in several clinical reports in the *Transactions* for 1859. These reports described a case of croup with excessive false membrane formation and the operations of episiorrhaphy and laryngotracheotomy (the latter necessitated by aspiration of a peanut into a child's trachea). In 1864, as chairman

of the Society's scientific committee, he published a study, "On Hospital Gangrene", a topic of much importance during the then-raging Civil War. In the next year the Society printed his report describing a patient who required ligation of the external iliac artery to obliterate an aneurysm of the femoral artery. Dr. Coles' wide scientific interests were also reflected by numerous articles published during subsequent years.

Aware of his accomplishments, The Medical Society of New Jersey elected Abraham Coles third vice-president for 1860-62, second vice-president in 1863, first vice-president during the next year, and president for one year from January 24, 1865. Coincident with this last honor was his chief contribution to the poetry of medicine. This was "The Microcosm," a long poem which he read as part of his presidential address to the Society at its Centennial Meeting held in the chapel of Rutgers College on January 24, 1866.

THIS "physiological poem," prefaced by Socrates' dictum, "Know Thyself," was patterned after the Latin epic poem, *De rerum natura* (On the Nature of Things), by Lucretius (a Roman poet who lived almost a century before Christ, yet promulgated broad concepts about the universe, ranging from atoms to supernovae). In "The Microcosm", Coles attempted to present in poetic form a compendium of science concerning the human body. Through this work he combined scientific analysis and religious sentiment in a novel fashion. "I offer no apology for mixing up my Religion with my Science", wrote the author in his prefatory remarks. The stately passages and quaint flavor of "The Microcosm" have been compared to the poetry of George Herbert (on the religious side) and to the verse of the elder Darwin (on the naturalistic side). (Erasmus Darwin was another physician-poet who, in "The Botanic Garden", sowed the seeds of the later revolution in science effected by his grandson, Charles Darwin).

The sections of "The Microcosm" entitled, *Charity, Physician, Opiferque per orbem dicor* (the latter our Society's Latin motto) and *Physician's Character and Aims — Science*

Progressive, pertain directly to medical practice and are worthy of quotation:

O Ye devoted to the Healing Art
By solemn consecration, set apart
To be the ministers of God above
In the sublime Activities of Love;
Whose special function 'tis to give relief
In the dark hour of suffering and of grief;
Between the living and the dead, to stand
Where fall the shafts of death on either hand;
Without one thought of flight, to still maintain
Perpetual battle with the Powers of Pain . . .

O it is well that ye have hearts to feel
And ears not deaf to pity's soft appeal,
Putting no difference 'twixt rich and poor,
Plying with equal zeal the means of cure,
Not deeming it becoming to regard
Color or rank or person or reward.

"Knowledge is power", and here 'tis power to
save,

A power like God's to rescue from the grave.
Each Year adds something—many things ye know
Your sires knew not a Hundred Years ago;
Art grown to more, your sons will higher climb,
And make the Coming Centuries sublime:
Till Christ's Millennial Kingdom shall begin,
And put an end to sickness and to sin . . .

Originally printed in the Society's *Transactions* for 1866, this work was later published in 1881 together with Coles' "National Lyrics" and "Miscellaneous Poems" as, "The Microcosm and Other Poems". (Among his patriotic lyrics were a sonnet composed in honor of President Lincoln during the Civil War and a poem dedicated to President Garfield at the time of the latter's assassination). So popular was Dr. Coles' poetry at the time that it took five editions to supply the demand. In the fifth edition, a special edition dedicated to physicians, were included illustrations of medical heroes—Paré, Vesalius, Harvey, Jenner—among others.

ABRAHAM COLES is remembered today chiefly as a writer and translator of hymns. He astonished the contemporary literary world by publishing eighteen different versions of the celebrated Latin hymn *Dies Irae* (Day of Wrath) during his lifetime. (Originally written by the Italian monk, Thomas of Celana, in the thirteenth century, this chant vividly describes the Judgment Day. Its rhythm, set to music, forms a prominent part of Mozart's

Requiem and many other major musical compositions. English translations of *Dies Irae* were made, among others, by the poets Crasshaw, Macaulay and Sir Walter Scott). Dr. Coles' many versions of this Judgment hymn, the first published in 1847, evidenced a surprising mastery of language and illustrated the possibilities of a wide variation in verse without alteration of its meaning:

Dies irae, dies illa
Solvat saeculum in favilla,

Lacrymosa dies illa
Qua resurget ex favilla.
Judicandus homo reus,
Huic ergo parce Deus.
Pie Jesu, Domine,
Dona eis requiem.

Day of wrath, that day of burning
All shall melt, to ashes turning,
Ah! that dreadful day of weeping,
When the dead in ashes sleeping,
Wake to hear their doom eternal;
Save then, Lord, from pains infernal.
Jesus, of all beings best,
Give to them eternal rest.

So popular was Coles' translation of *Dies Irae* that part of it found its way into Harriet Beecher Stowe's novel, "Uncle Tom's Cabin" (1852). Also Henry Ward Beecher included a musical version of it in his "Plymouth Collection of Hymns and Tunes".

Dr. Coles also translated the medieval hymns, *Stabat Mater Dolorosa* and *Stabat Mater Speciosa*, and these, together with a collection of hymns entitled "Old Gems in New Settings", ran through several editions and are still standbys in standard hymnals. Among his better-known translations were those of *O Filii et Filiae, Veni Creator Spiritus* and *Veni Sancte Spiritus*. One of his most popular original hymns was "In the Sweet By and By"—lines still familiar today:

There's a land that is fairer than day,
And by faith we can see it afar;
In the sweet by and by,
We shall meet on that beautiful shore.

John Greenleaf Whittier, commenting on his friend's hymnology, said: "Dr. Coles is a born

hymn writer. No man . . . has so rendered the text and the spirit of the old and wonderful Latin hymns . . . He has left us a legacy of inestimable worth, some of the sweetest of Christian hymns. His 'All the Days' and his 'Ever With Thee' are immortal songs. It is better to have written them than the stateliest of epics". Coles' hymns were praised with equal enthusiasm by his contemporaries Henry Wadsworth Longfellow, William Cullen Bryant, James Russell Lowell, Prime Minister William Gladstone of England—and others. Today many of us know the Centennial President of The Medical Society of New Jersey through his immortal hymns. Because of these hymns he continues to be "a good neighbor and a kind friend" as the Rt. Rev. Michael Corrigan, Catholic Archbishop of New York, wrote of him at the time of Dr. Coles' death.

As a classical scholar Coles was proficient in Greek, Latin, Hebrew and Sanskrit, as well as several modern languages. In 1882 he translated *The Psalms of David* from Hebrew into English verse (with extensive historical and critical notes), a task previously done, in part, by the poet Milton. Other religious writings included, "The Evangel" (1874), a life of Christ in verse, and "The Light of the World" (1884). Oliver Wendell Holmes deemed "The Evangel" 'an impressive and charming book', and compared the simplicity of its verses to those of John Bunyan's "Pilgrim's Progress." Whittier augmented this opinion by describing "The Evangel" as 'a work of piety and beauty'.

Besides a distinguished career in medicine and in letters, Abraham Coles' civic and philanthropic interests were of great benefit to his home community. Serving several terms on the Newark Board of Education, he was also one of the founders of the Newark Public Library and of the New Jersey Historical Society. Active in religious circles, he was a founding member of the South Baptist Church in Newark and author of several tracts on Christian education. A fine monument to his honor was erected in Washington Park, Newark, in appreciation of his contributions as a citizen of that city.

THE lives and works of men such as Abraham Coles of New Jersey lend emphasis to Robert Louis Stevenson's tribute that the physician "is the flower (such as it is) of our civilization". Sir William Osler, writing about

medical poets and litterateurs, wisely added, "We should look beyond the printed page to find in the lines of these men the spirit of helpfulness which gives to the profession of medicine its value to humanity".

Donnelly Memorial Hospitals

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Scalene Node Biopsy

Daniels, in 1949, first described biopsying the scalene lymph nodes as a method for diagnosing certain chest diseases. He reported positive findings in the scalene nodes in two cases of Boeck's sarcoid, carcinoma of the lung, and silicosis with demonstration of the silica particles by means of a Nicol prism. Subsequent authors have reported positive findings in these nodes in three cases of Hodgkin's disease and histoplasmosis.

The value of this type of biopsy is due to the fact that the lymph nodes anterior to the scalenus anticus muscle are linked to the mediastinal nodes. Thus, pulmonary lesions which might involve mediastinal nodes, or mediastinal disease itself, is reflected in the scalene nodes. In this sense, a simple scalene node biopsy is a biopsy of the mediastinal nodes without requiring a thoracic operation.

Shefts, Terrill and Swindell,* have recently presented their experiences with two hundred and five scalene node dissections, seventeen of which were bilateral, in one hundred and eighty-seven patients. All nodes were examined by H and E stains and Ziehl-Neelsen smears when indicated. Hotchkiss-McManus stains were done in instances of nodes positive for Boeck's sarcoid. In the latter part of the study routine cultures were made from the nodes for both tubercle bacilli and fungi.

Complications were limited to involvement of the thoracic ducts. The left thoracic duct was torn once, the right twice.

In the present series of one hundred and eighty-seven patients, an accurate diagnosis was made only by scalene node biopsy. If other methods such as bronchoscopy or sputum studies disclosed the diagnosis it was excluded from this series.

Of the one hundred and eighty-seven patients biopsied, sixty-seven had abnormal scalene nodes. The pathologic conditions found in this series were Boeck's sarcoid in thirty-eight; bronchogenic carcinoma in thirteen; tuberculosis in eight; lymphosarcoma in two; Hodgkin's disease in two; and histoplasmosis in one. In three cases there were metastases to the lung from carcinoma of the pancreas, hypernephroma, and carcinoma of the cervix. It was recommended that the scalene node on the same side as the principal intrathoracic disease be chosen for biopsy. Where there is no pulmonary lesion and the enlargement of the mediastinum is equal bilaterally, the highest percentage of positive nodes will probably be found on the left.

The procedure is recommended for its simplicity and accuracy in the diagnosis of suitable intrathoracic conditions.

*Shefts, L. N., Terrill, A. A., and Swindell, H.: Scalene Node Biopsy. Am. Rev. Tuberc. 68:505, October, 1953.

Diabetes Mellitus in a Mongoloid*

The previously unreported combination of diabetes and mongolism is described in a four-year old child. Unusual features of the metabolic changes are presented.

DIABETES mellitus is a rare finding in mongoloid children—no previous record of these two conditions occurring concomitantly could be found in the literature.

Benda¹ has consistently found the fasting blood sugar values of mongoloid patients to be normal. Sugar tolerance, however, is increased in these children as shown by the frequency of flat curves. This case is reported because diabetes mellitus has not previously been reported as a complication of mongolism.

CASE REPORT

D. U., a 4-year old white mongoloid girl, was first hospitalized at two and one half years of age because of increasing listlessness, polyphagia and polyuria of about 5 days' duration. A diagnosis of diabetic acidosis was made on the basis of four plus glycosuria and acetonuria associated with a blood sugar of 530 mg. per cent, a serum carbon dioxide¹ content of 6.8 mEq. and a serum chloride value of 86 mEq. per liter. The abnormal electrolyte pattern was easily corrected by parenteral fluid. The initial insulin requirements were determined by the method of Brush.² She was discharged after approximately 3 weeks' hospitalization on 4 units of protamine zinc insulin daily.

In the ensuing two and one half months she remained in good health. Her daily insulin need, however, rose to 12 units of protamine zinc insulin. She was admitted to the United States Naval Hospital, Philadelphia for the first time on May 27, 1952,



with a high fever and incipient coma caused by an acute follicular tonsillitis. The blood sugar value was 464 mg. per cent, and the serum carbon dioxide content 12 mEq. per liter. Response to fluids, antibiotics, and increased insulin was prompt.

She was last hospitalized on May 30, 1953, at the age of three and three-quarter years, for re-evaluation of the severity of the diabetes and for treatment of an upper respiratory infection. On admission she had a fasting blood sugar of 220 mg. per cent and three plus glycosuria. Several fasting blood samples revealed an average glucose value of 240 mg. per cent (range 123-350 mg. per cent). Her insulin requirement was increased to 10 units of regular insulin and 15 units of protamine zinc insulin daily. Urines remained sugar-free on this insulin dosage. She was given a daily diet of 1200

* From the Pediatric Service of the U. S. Naval Hospital, Bethesda, Maryland.

The opinions or assertions contained in this article are the private ones of the writer and are not to be construed as official or reflecting the views of the Navy Department or the naval service at large.

† Medical Corps, United States Navy.

calories consisting of 110 grams of carbohydrate, 55 grams of protein, and 60 grams of fat.

The reducing substance in her urine was proved to be glucose. An oral glucose tolerance test, as well as an epinephrine tolerance test, were performed after the respiratory infection had cleared. The values obtained are recorded in Table 1.

TABLE 1.

VALUES FOR ORAL GLUCOSE AND
EPINEPHRINE TOLERANCE TESTS,
MILLIGRAMS PER CENT

Test	Fasting	Minutes			
		30	60	120	180
Glucose Tolerance	123	255	341	394	327
Epinephrine Tolerance*	107	124	134	144	174

* 0.4 cc. of 1:1000 solution of epinephrine were given subcutaneously.

The glucose tolerance curve was compatible with the diagnosis of diabetes mellitus. The epinephrine tolerance values were somewhat lower than normal, indicating either a loss of hepatic glycogen stores or a slower than normal rate of glycogen breakdown.

Of interest in the family history was that the parents were in their early twenties when the patient was born. There was no family history of diabetes mellitus. Birth weight was 5 pounds, 10 ounces. Except for many respiratory infections since birth her health has been good. Growth and development have been satisfactory for a mongoloid child. She sat alone at 12 months, walked at 22 months, and cut her first tooth at 13 months. When last seen at 4 years of age, she weighed 35 pounds and was 34½ inches tall.

108 N. Stanworth Drive

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DISCUSSION

THE fact that diabetes mellitus has been encountered in a mongoloid child is not in itself of great significance. However, the occurrence of such a case may add some information that will help in the eventual understanding of the pathogenesis of mongolism.

This child's glucose tolerance curve was that of a diabetic. As mentioned previously, the sugar tolerance curve in mongolism usually shows a delayed glycemic response. Benda¹ has also performed a number of intravenous glucose tests on mongoloid patients. It was found that in most instances the blood glucose of the mongoloid subjects continued to rise after the second half-dose instead of falling normally. This is further evidence that the carbohydrate metabolism is abnormal in mongolism. Wickström³ has also demonstrated that intravenous glucose tests are abnormal in the mongoloid patient. No previous report, however, has described the markedly abnormal glucose tolerance curve found in the present case.

SUMMARY

A CHILD with mongolism and diabetes mellitus is presented. This is the first reported case of these two conditions occurring concomitantly. It is reported to add information which may prove of value in the eventual understanding of the pathogenesis of mongolism. A brief discussion of carbohydrate metabolism studies in mongolism is also given.

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NATHAN SCHAFFER, M.D.

East Orange

EDWARD E. SEIDMON, M. D.

Plainfield

Mold Content of Air: Clinical Aspects*

This careful investigation indicates the importance of fungi in allergy, their prevalence in New Jersey, and their antigenic capacity. Identification of fungi in air and house dust has been done, with a study of concentration and seasonal incidence.

HERE are three groups of allergic patients which present a baffling diagnostic and therapeutic problem to all physicians in this area. The first group consists of those patients who have seasonal-like exacerbations in mid-January or mid-February which continue until a good killing frost in the fall, or have occasional flare-ups resembling pollen allergy either from January or February to May, from early July through the middle of August, or from mid-October to frost. These patients may or may not also be sensitive to the pollen of trees, grasses, or weeds.

The second group is made up of those patients with symptoms on a perennial basis, with or without sensitivity to pollen, dust or inhalants. The third group consists of those patients who have symptoms with damp, humid weather, summer or winter, again with or without sensitivity to pollens, dust, or inhalants.

To determine any new airborne allergies which could possibly be present in the above situations, air surveys were begun in 1948, using the Wells Air Centrifuge to make twenty-four hour studies of air. Pollen grains were easy to identify but trouble was encountered

in identifying the spores of fungi from the air strips alone. An air centrifuge was then placed at the Department of Plant Pathology, School of Agriculture, Rutgers University, New Brunswick. This machine was used to make cultures twice a week of a fixed amount of air, and culture counts were done for two years. All culturing was done in serial dilutions so that slow-growing organisms could be recovered. This method was only good for those fungi which could be cultured in the laboratory. Some fungi which are in the air in large quantities, such as the rusts, smuts, mushrooms, and mildews, cannot be cultured, and therefore were identified from the library of plant pathology at the University and by field trips which sought their habitat in nature.

The results were tabulated after twenty months, two entire summers having been studied. Table 1 shows fungi isolated; fifty-one culturable organisms were recovered, fifty of these being identified. Figure 1 shows a distinct incidence curve, with a peak in July and a low in February. The variations in the two years were probably due either to a sudden appearance of a new fungus in large numbers, or to a specific disease of a plant, and also to differences in temperature, humidity, rainfall, and wind direction.

* Sponsored by the New Jersey Allergy Society. Read before the Section on Allergy at the Annual Meeting of The Medical Society of New Jersey on May 19, 1953.

Ninety-five per cent of the total colonies were made up of the twelve fungi shown in Table 2.

TABLE 1

LIST OF FUNGI CULTURED FROM AIR

1. Acrostalagmus	27. Pestalozzia
2. Alternaria	28. Phoma
3. Aspergillus	29. Phomopsis
4. Botrytis	30. Pleospora
5. Cephalosporium	31. Pullularia
6. Chaetomium	32. Rhizopus
7. Coniothryium	33. Scopulariopsis
8. Cunninghamella	34. Sepedonium
9. Curvularia	35. Spicaria
10. Cylindrocarpon	36. Sporotrichum
11. Dicoecum	37. Stachybotrys
12. Diplodia	38. Stemphyllium
13. Epicoccum	39. Streptomyces
14. Fusarium	40. Strumella
15. Fusicoccum	41. Stysanus
16. Gloecercospora	42. Thamnidium
17. Helminthosporium	43. Torula
18. Hormodendrum	44. Trichoderma
19. Hyalopus	45. Trichothecium
20. Monilia	46. Yeast
21. Monotospora	47. Zygorhynchus
22. Mucor	48. Sphaerotheca
23. Nigrospora	49. Pseudo-stemphyllium
24. Oospora	50. Isaria
25. Paecilomyces	51. Unknowns
26. Penicillium	

RECOVERED BUT NOT CULTURED

Rusts	Mushrooms
Smuts	Puffball
Mildews	

TABLE 2

1. Hormodendrum	7. Cylindrocarpon
2. Penicillium	8. Stemphyllium
3. Alternaria	9. Botrytis
4. Epicoccum	10. Fusarium
5. Pullularia	11. Helminthosporium
6. Aspergillus	12. Phoma.

Figures 2 and 3 give the individual curves of each of these fungi.

When these twelve most common fungi are removed from the seasonal incidence curve, the remaining thirty-nine organisms present a new curve.

Figure 4 shows that these fungi are present all year round, with the low point reached in May. The November high was due to the appearance of an unidentified fungus which appeared one year in great quantity. These thirty-nine organisms represent five per cent of all the fungi cultured.

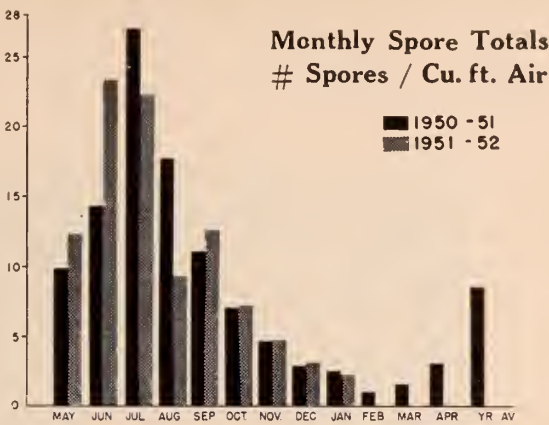


Figure 1.

As all airborne substances finally settle indoors as well as outdoors, samplings of house dusts were collected for mold culturing. Using a vacuum cleaner with a baffle, thirty-three house dust samples were collected from mattresses and overstuffed furniture and serial dilutions were plated. Thirty-seven fungi were cultured and showed a close parallel to the organisms found in air. Table 3 lists the fungi cultured from house dusts.

TABLE 3

1. Aspergillus	20. Hyalopus
2. Penicillium	21. Sepedonium
3. Pullularia	22. Botrytis
4. Epicoccum	23. Olpitrachum
5. Scopulariopsis	24. Pleospora
6. Hormodendrum	25. Coniothryium
7. Gliocladium	26. Pseudostemphyllium
8. Alternaria	27. Helminthosporium
9. Sphaeropsis	28. Sacromyces
10. Trichoderma	29. Oospora
11. Curvularia	30. Streptomyces
12. Fusarium	31. Monotospora
13. Chaetomium	32. Oedocephalum
14. Mucor	33. Acrostalagmus
15. Pestalozzia	34. Nigrospora
16. Cephalosporium	35. Monilia
17. Phoma	36. Sporotrichum
18. Rhizopus	37. Unknowns
19. Stemphyllium	

It should be noted that large numbers of bacteria and chemical crystals were found both in air and house dusts and that house dusts also contained large numbers of all the pollen that are present in air. Neither the bacteria nor the chemical elements have been identified or studied from the allergic standpoint as yet.

The fungi most often found in house dusts are listed in Table 4.

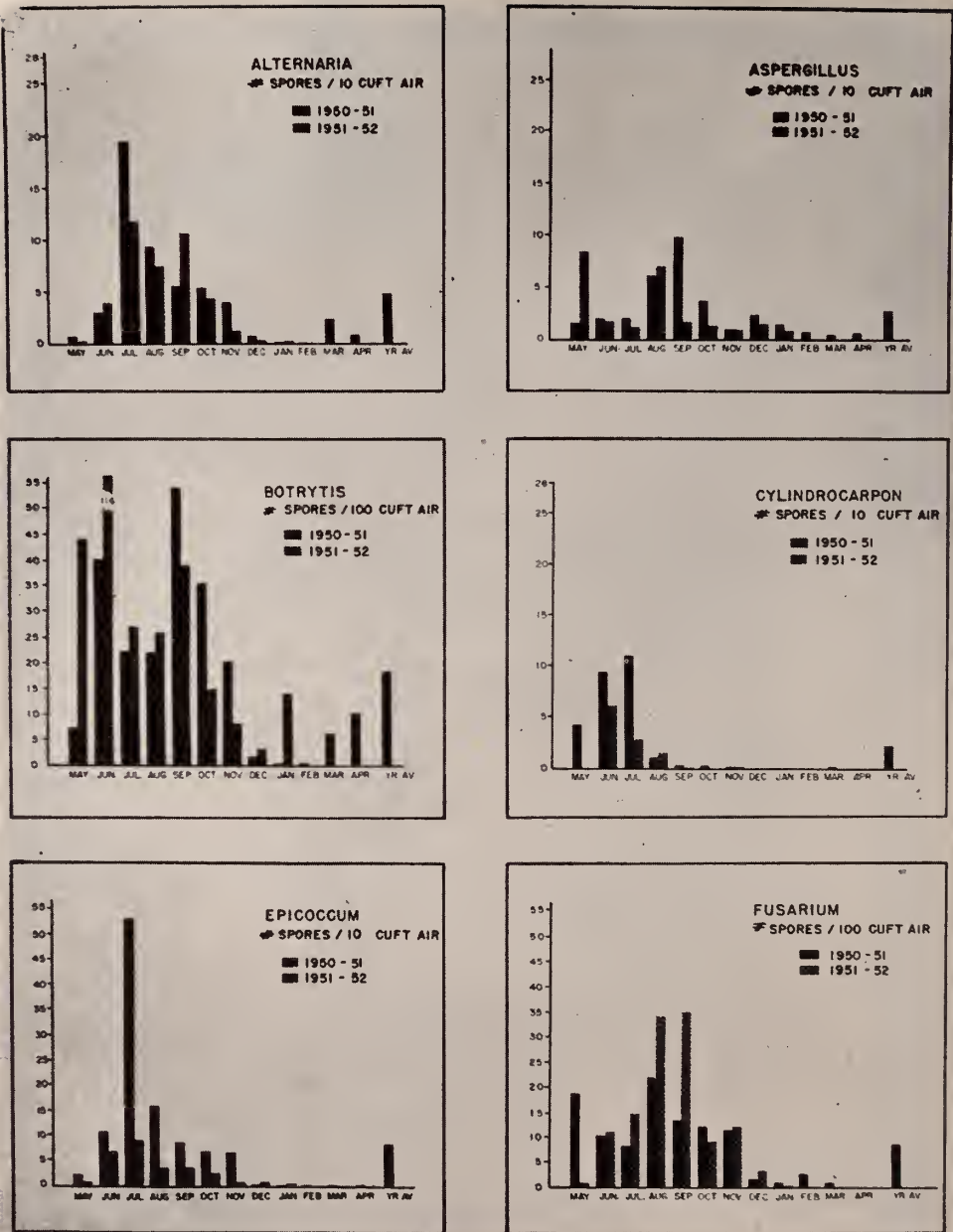


Figure 2.

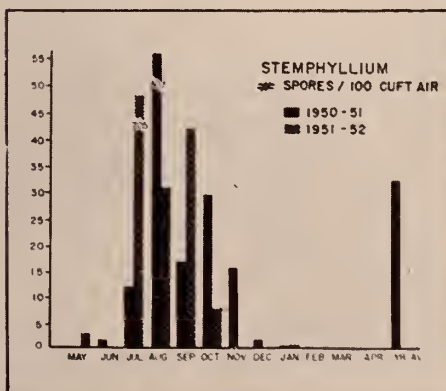
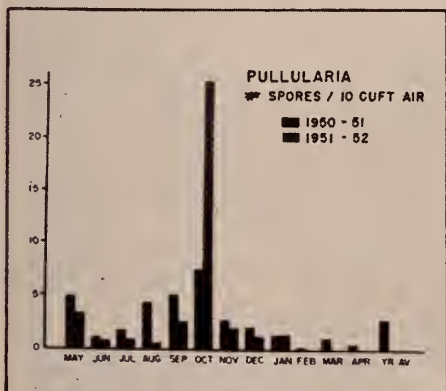
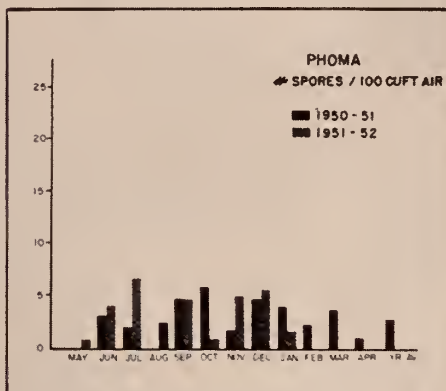
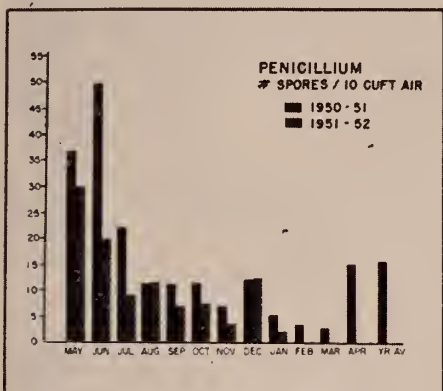
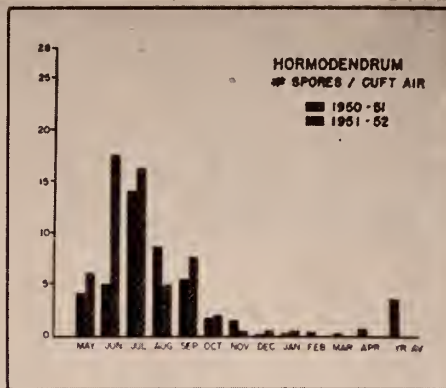
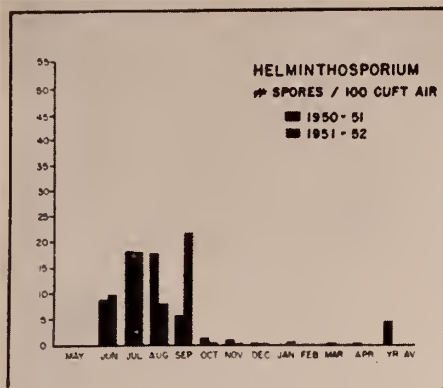


Figure 3.

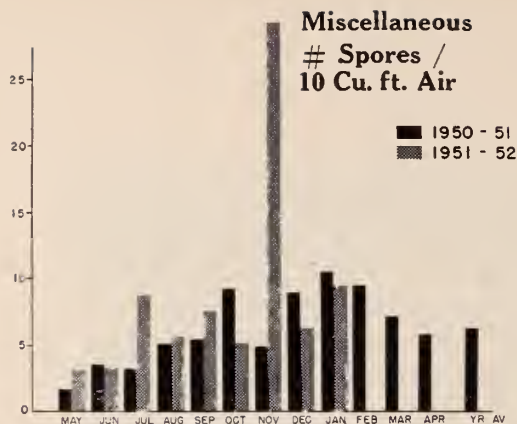


Figure 4.

TABLE 4

1. Penicillium	7. Stemphyllium
2. Pullularia	8. Epicoccum
3. Aspergillus	9. Phoma
4. Mucor	10. Rhizopus
5. Alternaria	11. Scopulariopsis
6. Hormodendrum	12. Fusarium

Table 5 gives the fungi most common to both groups (air and house dust) :

TABLE 5

1. Hormodendrum	6. Pullularia
2. Penicillium	7. Aspergillus
3. Alternaria	8. Fusarium
4. Epicoccum	9. Botrytis
5. Stemphyllium	10. Phoma

After noting the incidence curves obtained in the air studies and the duplication of the fungus population of house dust, it was deemed advisable to test a group of fifty patients who fell into the first class as described at the start of this paper—those who had difficulty during the so-called pollen free periods of the year—with all the fungus extracts made from recovered organisms.

Table 6 shows the skin reactions in five patients whose symptoms appeared either in mid-January or February.

SYMPTOMS APPEAR MID-JANUARY OR FEBRUARY

REACTIONS																
NUMBER	PATIENT	SYMPTOM	DUST	TREES	GRASSES	WEEDS	ALTERNARIA	HORMODENDRUM	PENICILLIUM	ASPERGILLUS	PULLULARIA	SCOPULARIOPSIS	CEPHALOTHECIUM	EPICOCUM	PHOMA	BOTRYTIS
1	A.G.	Asthma	++	+							++ ++	++ ++	++ ++			
2	P.M.	H.F. Asthma	++ ++	++ +			++ ++ +								++ ++ +	++ ++ ++ +
3	B.S.	Asthma	++ ++	++ ++			++ ++ +				++ ++					
4	L.M.	Asthma	++ ++ +				++ ++ +	++ ++ +						++ ++ +	++ ++ +	
5	S.S.	Asthma	++ ++	+			++ ++ +	++ ++ +		++ ++ ++ +					++ ++ ++ ++ COAR.	++ ++ ++

Table 6.

Table 7 shows skin test results on twenty-three patients who had symptoms in July and August.

Table 8 shows reactions of four patients with symptoms from October to frost.

Table 9 shows skin reactions in three patients with symptoms starting in mid-February and also in July and early August.

Table 10 shows results in ten patients with symptoms in July and early August, and October to frost.

Table 11 shows the skin reactions in five patients with symptoms from February to frost.

After testing, the fungus extracts giving positive skin reactions were added to the rou-

SYMPTOMS IN JULY AND EARLY AUGUST																						
NUMBER	PATIENT	SYMPTOM	REACTIONS																			
			OUST	TREES	GRASSES	VEEOS	ALTERNARIA	NORMOEHORUM	PENICILLUM	ASPERGILLUS	PULLULARIA	EPICOCCUM	PHOMA	STEMPHYLLUM	BARLEY SMUT	CORN SMUT	SPOROCLADIUM	BOTRYTIS	SCOPULARIOPSIS	MILDEV	HELMINTHOSPORIUM	ACROSTALAGMUS
1	J.C.	Asthma	++	++	+				++	++				++								
2	G.A.	Asthma	++		+		++	++			++				++							
3	L.B.	H.F.	++		++		++	++														
4	D.B.	Asthma	++												++	++	++					
5	W.O.	Asthma			+	++	++	++									++					
6	A.E.	Asthma	++	++	++	++	++	++	++					++								++
7	M.F.	Asthma	++							++	++	++	++	++				++	++	++	++	++
8	D.H.	Asthma	++	++	++	++	++	++			++	++	++	++			++				++	++
9	F.K.	H.F.		++	+		++	++			++	++	++	++								
10	M.K.	Asthma	++	+			++			++	++	++	++				++	++				++
11	A.O.	Asthma	++											++			++	++			++	++
12	J.S.	Asthma	++		++	++	++		++			++	++				++					
13	L.S.	H.F.	++		++	++				++									++			++
14	D.S.	Asthma	++			++	++	++	++													++
15	C.W.	Asthma					++	++	++				++					++				++
16	M.B.	Asthma	+	++	++	++	++	++	++													
17	N.B.	Asthma	++	++	++	++	++			++	++							++	++			++
18	J.Z.	Asthma			++	++	++			++	++											
19	M.N.	Asthma	++		++	++	++			++												++
20	P.P.	Asthma	++		+	++	++			++					++							++
21	M.T.	Asthma			+	++	++	++				++										++
22	J.H.	H.F.	++		++	++	++	++		++												
23	K.P.	Asthma		++	+	++	++													++		

Table 7.

tine treatment. The results obtained were excellent—symptoms in these patients were controlled.

DISCUSSION

Air sample cultures revealed the presence of fifty-one culturable fungi in northern New Jersey over a twenty month period. These

fungi have a distinct incidence curve with the peak in June and July. Twelve fungi make up 95 per cent of the total colonies recovered. The remaining thirty-nine fungi, 5 per cent of the total, give a plateau-like curve of yearly incidence with the low point in May. These curves may have variations due to conditions of climate or special plant pathology favoring

SYMPTOMS IN OCTOBER AND LASTING TO FROST

REACTIONS														
NUMBER	PATIENT	SYMPTOM	DUST	TREES	GRASSES	WEEDS	ALTERNARIA	HORMODENDRUM	ASPERGILLUS	HELMINTHOSPORIUM	PULLULARIA	BOTRYTIS	BLACKBERRY RUST	EPICOCOCCUM
1	M.B.	Asthma	++	++	++	++	++			++	++	++		
2	J.A.	Asthma	++			++	++					++		++
3	A.P.	H.F.	++				++	++				++		
4	B.W.	Asthma	++			++	++		++		++		++	++

Table 8.

SYMPTOMS MID - FEBRUARY AND IN JULY

REACTIONS														
NUMBER	PATIENT	SYMPTOM	DUST	TREES	GRASSES	WEEDS	ALTERNARIA	HORMODENDRUM	ASPERGILLUS	PULLULARIA	BOTRYTIS	MILDEW	FUSARIUM	HELMINTHOSPORIUM
1	A.H.	Asthma	++			++	++		++	++	++	++		
2	S.C.	Asthma	++	++		++	++	++					++	++
3	J.G.	Asthma	++	++	++	++	++			++				++

Table 9.

SYMPTOMS JULY-AUGUST AND OCTOBER TO FROST

NUMBER	PATIENT	SYMPTOM	REACTIONS																								
			DUST	TREES	GRASSES	WEEDS	ALTERHARIA	HORMODENDRUM	PENICILLIUM	ASPERGILLUS	PULLULARIA	SCOPULARIOPSIS	FUSARIUM	WHEAT SMUT	EPICOCUM	DIPLODIA	CHAETOMIUM	MILDEW	STEMPHYLLIUM	FUNGUS X	PHOMA	HELMINTHOSPORIUM	BLACKBERRY RUST	TORULA	BOTRYTIS	OAT SMUT	
1	N.B.	Asthma	++	++	++	++	++	++	++			++	++														
2	L.B.	Asthma					++	++	++					++	++						++	++					++
3	W.B.	Asthma	++		++	+	++	++	++							++	++	++	++		++	++					
4	P.C.	Asthma	++		++	++	++	++	++		++	++	++	++	++	++	++	++	++	++							
5	R.C.	Asthma	++	+		++	++	++	++		++	++							++	++							
6	N.J.	Asthma	++	++		++	++	++	++		++	++		++	++						++	++	++				
7	B.L.	Asthma	+		++	++	++	++	++				++										++	++	++	++	
8	G.R.	Asthma	++		++	++	++	++		++	++			++						++	++						++
9	M.K.	Asthma	++	++	++	++	++	++		++													++	++	++	++	
10	D.P.	Asthma	++			++	++	++			++	++							++	++							

Table 10.

SYMPTOMS FEBRUARY THRU FROST

REACTIONS																			
NUMBER	PATIENT	SYMPTOM	DUST	TREES	GRASSES	WEEDS	ALTERNARIA	HORMODENDRUM	ASPERGILLUS	PULLULARIA	SCOPULARIOPSIS	CEPHALOTHECIUM	PHOMA	HELMINTHOSPORIUM	WHEAT SMUT	BOTRYTIS	CORN SMUT	ACROSTALAGMUS	MYCOGONE
1	L.B.	Asthma	++ +	++ +	++ +	++ +	++ +	++ +	++ +									++ +	++ +
2	A.D.	Asthma	++ +	++ +	++ +	++ +	++ +	++ +		++ +									
3	E.K.	Asthma	+			+	++ +					++ +		++ +					
4	H.B.	Asthma	+					++ +					++ +		++ +		++ +		
5	B.F.	Asthma	++ +	++ +	++ +	++ +	++ +	++ +	++ +		++ +					++ +	++ +		

Table 11.

any one fungus. Non-culturable fungi, smuts, rusts, mildews and mushrooms are also present in the air in large numbers.

On culturing thirty-three house dust samplings, thirty-seven of the fifty-one organisms found in air were recovered. Viable fungi are present throughout the entire year in large numbers in house dust and can play an important role in producing perennial symptoms in certain allergic patients, or accentuating seasonal symptoms. Though some of the fungi, such as *Alternaria* for example, are not present in large quantity in the air during the winter, they are present in house dust. In a mild, damp winter, with a January or February thaw, these fungi can appear locally in dead leaves, humus, etc., and cause symptoms.

Testing of fifty allergic patients complaining either of asthma or vasomotor rhinitis or both was done with fungus extracts with the following results:

1. Five patients with symptoms in January and February reacted to two or more fungi proved to be present either in air or house dust at that time.

2. Twenty-three patients with symptoms beginning in July, and lasting through early August, a so-called timothy and ragweed pollen-free period, reacted to two or more of the most common fungi known to be airborne at this time.

3. Four patients with symptoms in October and lasting to frost, a period after ragweed has stopped pollinating, gave reactions to three or more of the important fungi.

4. Three patients with symptoms beginning in February and also severe in July and early August reacted to four or more of the fungi.

5. Ten patients with symptoms both in July and early August, and from October till

frost, times when no important airborne pollen are present, reacted to four or more fungi.

6. Five patients with symptoms from February until frost reacted to three or more of the fungi.

In all of these cases, the addition of positive reactors to routine treatment gave excellent results.

SUMMARY

1. Fifty identifiable and culturable fungi have been recovered from air.

2. Thirty-six identifiable fungi have been recovered from thirty-three house dust samples.

3. These fungi show a constant presence in air or house dust throughout the year, which is of importance in considering perennial symptoms of allergy, or seasonal exacerbations.

4. Fifty cases of allergic vasomotor rhinitis and asthma or both have been tested with these fungi with positive results to two or more of the important fungi.

5. Forty-one of the fifty cases had symptoms during July and early August, a period of the summer when timothy and ragweed pollen are unimportant as allergens, and when the most important fungi are in the air in the greatest concentrations.

6. Treatment with specific fungus extracts gave excellent results.

7. Greater stress must be placed on the importance of fungi in inhalant seasonal allergy, and plant pathogens such as rusts, smuts, mildews, and mushrooms, which cannot be cultured in the laboratory, must also be considered clinically important in this area.

Acknowledgment is made for the invaluable assistance of Drs. C. M. Haensler and B. H. Davis, and Miss Sybil Breskin, M.A., of the Department of Plant Pathology, College of Agriculture, Rutgers University, New Brunswick, New Jersey.

98 South Munn Avenue, East Orange

221 West 7th Street, Plainfield

Announcements • • •

AACP Meeting

The New Jersey Chapter of the American College of Chest Physicians announces that its winter meeting will be held on Tuesday, February 23, at the B. S. Pollak Hospital, 100 Clifton Place, Jersey City, at 8:30 p.m. Drs. R. M. Harvey and M. I. Ferrer of Columbia University and Dr. R. J. Simpson of the Pollak Hospital, will discuss pulmonary emphysema and cor pulmonale.

All interested physicians are invited.

Orthopsychiatric Meeting

The American Orthopsychiatric Association will hold its 31st annual meeting at the Hotel Commodore, New York City, March 11-13.

Scientific papers will be presented by psychiatrists, psychologists and workers in allied fields.

Further information may be obtained from Dr. Marion F. Langer, 1790 Broadway, New York 19, N. Y.

Medico-Legal Meeting

The New Jersey Neuropsychiatric Association announces a medico-legal meeting to be held at the Academy of Medicine, Newark, on Wednesday evening, March 24.

The subject to be discussed is the Briggs Law, and its relationship to psychiatric testimony. Members of the medical and legal professions are invited to attend.

Obstetrics Meeting

The Obstetrical and Gynecological Section of the Academy of Medicine of New Jersey and the State Society Maternal Welfare Committee announce a meeting to be held on Thursday, February 25 at 8:30 p.m., at the State Medical Society Headquarters in Trenton. The subject for discussion will be maternal fatalities.

This meeting will follow one for the field physicians and the Medical Society's Maternal

Welfare Committee at 3:00 p.m. There will be a "Dutch treat" dinner between meetings. Physicians interested in attending this dinner will please make reservations with Dr. John D. Preece, 192 West State Street, Trenton 8, N.J.

Philadelphia Postgraduate Institute

The Philadelphia County Medical Society will hold its annual Postgraduate Institute at the Bellevue-Stratford Hotel March 30—April 2. A variety of subjects of interest to the practicing physician will be covered. Non-members of the Philadelphia Society are required to pay a registration fee of \$10.00.

Plastic Surgery Prizes

The Foundation of the American Society of Plastic and Reconstructive Surgery announces its fifth annual scholarship contest. Two prizes are offered for essays describing original research in the field of plastic and reconstructive surgery. Manuscripts must be submitted by July 1. Further information may be obtained from Jacques W. Maliniac, M.D., 30 Central Park South, New York, N. Y.

N-P Association Officers

The New Jersey Neuropsychiatric Association has elected the following officers for 1954:

President: Dr. Frank Pignataro, Red Bank; President-Elect: Dr. J. Lawrence Evans, Jr., Englewood; Secretary: Dr. Ira S. Ross, Newark; and Treasurer: Dr. Evelyn Ivey, Morristown.

Centenarians Sought

Dr. Roy W. Goshorn, Superintendent of the Allentown State Hospital in Allentown, Pa., is undertaking a research project on persons 100 years of age or older. He wishes to obtain the name and address of all such persons in New Jersey. Any physician who has patients of this age is requested to communicate with him at the Allentown address.

Proctology Convention

The International Academy of Proctology announces that its sixth annual convention will be held at the Palmer House, Chicago, April 8-11. The scientific session will cover recent developments in proctology and gastroenterology. The program has been designed for general practitioners as well as specialists.

Thyroid Meeting

The American Goiter Association announces its 1954 annual meeting, to be held at the Somerset Hotel in Boston, April 29—May 1. The program will consist of papers and discussions concerning physiology and diseases of the thyroid gland.

Laboratory Courses

The Division of Laboratories of the New Jersey Department of Health announces a series of refresher courses for medical laboratory technicians. On March 16 enteric bacteriology will be covered, followed in April by a course concerning prothrombin time determinations. Later in the year serologic tests for syphilis will be reviewed.

Qualified laboratory personnel may be registered for these courses by writing to E. L. Shaffer, Ph.D., Director of Laboratories, State House, Trenton, N. J.

Geriatrics Meeting

The American Geriatrics Society will hold its annual meeting at the Fairmont Hotel, San Francisco, June 17-19. Hotel reservations may be made through the San Francisco Convention and Visitors Bureau, 200 Civic Auditorium, San Francisco.

The meeting is open to all physicians interested in this field of medicine.

Vitamin Fellowships

The National Vitamin Foundation invites physicians and other scientists to become candidates for the Russell M. Wilder Fellowship. This fellowship will become effective September 1 and carries stipends ranging from \$4,500 to \$5,500. Applications must be submitted before March 15 and forms can be obtained from the National Vitamin Foundation, 15 East 58 Street, New York 22, N. Y.

Heart Association Meeting

The New Jersey Heart Association will hold its fifth annual seminar at the Mutual Benefit Life Insurance Company's auditorium, 300 Broadway, Newark, on Wednesday, March 17, starting at 2:00 p.m. Leading investigators in cardiology will discuss recent advances in their fields.

Obituaries • • •

DR. FRANK J. COUGHLIN

Dr. Frank J. Coughlin of Arlington died on November 28, 1953 at the age of 58.

Dr. Coughlin was born in Stratford, Ontario, and was a graduate of McGill University. He had been a resident physician at Kings County Hospital, Brooklyn, and served at the Brooklyn Eye and Ear Hospital before opening his practice in Arlington in 1928. Dr. Coughlin's practice was confined to otolaryngology. He was on the staff of West Hudson, St. Michael's and American Legion Memorial Hospitals. He was also affiliated with St. Mary's Hospital in Passaic for several years.

During World War I he served with the Royal Medical Corps, and during World War II was associated with the Selective Service Training Program. He was also past commander of the John Lindsay Canadian Legion Post in Kearny, and since

1932 had been chief ophthalmologist of the Kearny public schools. He was a member of the American Academy of Ophthalmology.

DR. ROBERT E. IMHOFF

Dr. Robert E. Imhoff died at his home in Moorestown on December 19, 1953, at the age of 52.

Dr. Imhoff was a graduate of Jefferson Medical College in 1927. He practiced in Moorestown until 1942 when he entered the Army. He served as executive officer of Station Hospital 42 during World War II.

After discharge from the Army he practiced dermatology in Camden. He was on the staffs of Cooper Hospital, Burlington County Hospital and Zurbugg Memorial Hospital, Riverside.

County Society Reports • • •

Atlantic

A regular meeting of the *Medical Society of Atlantic County* was held at the Traymore Hotel, December 10, 1953, Dr. E. Harrison Nickman, presiding.

Dr. Walter Stewart, chairman of the Communicable Disease Committee, offered for consideration a plan for a uniform quarantine law in Atlantic County.

Dr. Joseph G. Stella was elected to membership unanimously.

A proposed convention-cruise in lieu of the regular state convention in 1955, previously brought to the attention of the society at the November meeting, was again presented for discussion. The society voted against the proposal.

A Christmas greeting advertisement in the *Atlantic City Press* was approved.

The society had as its guests the clergy of Atlantic County, and they were welcomed by the president, Dr. Louis Krouse, Professor of Medicine, University of Maryland, presented "Medicine and the Bible" in a unique and fascinating manner.

A regular meeting of the *Medical Society of Atlantic County* was held at the Traymore Hotel on January 8, with Dr. E. Harrison Nickman presiding.

The guest speaker was Dr. William A. Fitts, Assistant Professor of Surgery, University of Pennsylvania School of Medicine. Dr. Fitts spoke on the diagnosis and treatment of lesions of the breast, and surveyed statistically the results of accepted methods of treatment.

Dr. Allman announced that the Constitution and By-Laws Committee, of which he is chairman, had completed a draft of a proposed revision of the constitution and by-laws, which was read. The revision will also be printed in the *Bulletin* and distributed to each member ten days before the meeting at which final action is to be taken.

Dr. Diskan, chairman of the Public Relations Committee, commented on the "Life for George Fund," a campaign currently receiving wide publicity in the *Atlantic City Press*. He stated that the facts as presented in the newspaper inadvertently emphasized only certain aspects of the situation, and did not portray clearly enough the role that is played daily by the local hospital and its staff. He recommended steps to correct this situation.

The society rejected endorsement of the 1954 March of Dimes campaign on the basis of establishing an unwise precedent.

LEONARD B. ERBER, M.D.
Reporter

Bergen

The regular monthly meeting of the *Bergen County Medical Society* was held on January 12, at

Bergen Pines Hospital, Paramus, with the president, Dr. Winton H. Johnson, presiding.

Dr. John E. Schults was elected to associate membership.

The proposed convention-cruise was briefly discussed. However, it was decided to defer action on this until next month.

Dr. Johnson also discussed the blood bank and stated that the land and the building had been bought by the Community Blood Bank. It was his opinion that the cost to patients would be less on a county-wide basis, and he stated that very shortly the officials of the Community Blood Bank and the heads of each hospital would establish uniform fees.

The guest speaker of the evening was Dr. Elmer L. Sevringhaus, Director of Clinical Research, Hoffmann-LaRoche Inc., who spoke on human nutrition.

JOHN E. McWHORTER, M.D.
Reporter

Camden

On December 1, 1953, President Edwin Ristine called to order the regular monthly meeting of the *Camden County Medical Society*. Dr. Louis A. Soloff, Assistant Professor of Medicine at Temple University School of Medicine, spoke on the unsolved problems of mitral commissurotomy. The speaker outlined new proposals for caution and restraint regarding valvular surgery.

Drs. Eugene R. Principato, Robert A. Haines and Harry Feilchenfeld were admitted to membership. Memoirs were read on the passing of Drs. Edgar Farrell and Claude Phillips.

FREDERICK W. DURHAM, M.D.
Reporter

Gloucester

An interesting scientific program opened the December meeting of the *Gloucester County Medical Society* held at the Woodbury Country Club, on the 17th. Dr. Joseph B. Vander Veer, Cardiologist at the Pennsylvania Hospital, Philadelphia, spoke on cardiovascular emergencies.

Dr. Ralph L. Moore presided at the business meeting. Dr. William I. Rozanski, of Glassboro was elected to membership.

A letter was read from the Lackawanna County Medical Society (Pennsylvania) protesting about articles in lay publications derogatory to the medical profession, and requesting censuring of the parties responsible.

The American Medical Association announced that early payment of the 1954 dues, regardless of past delinquencies, would permit any member to return to active status.

The society went on record as opposing the re-induction of any physician while eligible non-veterans were available for service.

LOUIS K. COLLINS, M.D.
Reporter

Hudson

The *Hudson County Medical Society* met in regular monthly session, with Dr. Joseph P. Donnelly presiding, on December 1, 1953, at Murdoch Hall, Jersey City Medical Center.

Dr. Donnelly announced that the society's new emergency and night call program will go into effect on January 1, with a listing in the January issue of the *Bulletin* of the names of doctors on call from January 1 through February 28, 1954.

Elected to active membership was Dr. Robert A. Richmond of North Bergen. The guest speaker was Dr. Edward A. Strecker, professor emeritus of the School of Medicine, University of Pennsylvania, who discussed the contributions of psychiatry to the theory and practice of medicine.

HARRY T. ARONOWITZ, M.D.
Reporter

Middlesex

The annual dinner meeting of the *Middlesex County Medical Society* was held on December 10, 1953, at The Pines, Metuchen, with doctors' wives as guests. Officers for 1954 were elected and installed.

Following the dinner, a humorous talk was given by the guest speaker, Houston Peterson, Professor of Philosophy, Rutgers University.

The following associates were elected to regular membership: Drs. Robert A. Ballou and Thomas M. Rein, New Brunswick, and Frank K. Corbett, South Plainfield. Dr. Paul Jannings of Highland Park was elected to associate membership.

The following officers were elected: *President*, Dr. Malcolm M. Dunham; *Vice-President*, Dr. Lavern C. Bassett; *Secretary*, Dr. Henry T. Weiner; *Treasurer*, Dr. George J. Kohut; *Reporter*, Dr. Ivan B. Smith.

In accordance with the amendment to the by-laws voted at the November 21 meeting, the annual meeting date has been changed from December to June, effective in 1955. Therefore officers taking office on January 1, 1954 will serve until May 31, 1955.

HAROLD V. CANO, M.D.
Reporter

Book Reviews • • •

Salt and the Heart. By Edward T. Yorke, M.D. Attending Cardiologist, Alexian Brothers Hospital, Elizabeth, New Jersey. Pp. 83, Drapkin Books, Linden, N. J. 1953 (\$3.45).

Physicians who prescribe salt free diets for their patients are constantly vexed by the individual who finds such a diet unpalatable. Although other authors have written books for the layman describing in simple terms the physiology of sodium retention in congestive failure and have prepared cooking manuals for such patients, Dr. Yorke has written an excellent little volume for them.

The book starts with an amusing illustrative "case report" concerning an old sea captain who has found it hard to adhere to his low salt diet and paid the penalty of repeated attacks of pulmonary edema. This leads to a discussion of the place of sodium in the body economy, the mechanism for controlling salt intake and excretion, and a brief summary of situations in which an increased salt intake is required. The major portion of the

book, however, is devoted to manifestations of cardiac failure clearly described in language that any literate layman can understand. Simple diagrams of the endocrine electrolyte regulators and of the heart are provided, as well as a discussion, again in simple language, of digitalis, diuretics, and cation exchange resins.

As one reads further he finds an excellent discussion of the metric system with emphasis on the milligram and the importance of conceiving of salt restriction in terms of this minute quantity, which is generally unfamiliar to the average layman. An excellent table indicates how many milligrams of sodium may be taken by the normal individual, patients on low salt diets, and those on markedly restricted low salt diets. Dr. Yorke has introduced a simple point system to enable the patient to determine roughly his sodium intake in milligrams. The system consists of assigning a number of points indicative of the number of milligrams of sodium in one hundred grams (3½ oz.) of food quantity, whether solid or liquid. For example, certain vege-

tables, such as asparagus, green beans and corn are assigned points which represent milligrams per 3½ oz. as 2, 1, and 0.3 respectively. High sodium vegetables, such as raw beets, chard and kale are given points to correspond with their sodium content in milligrams. These are respectively 110, 200 and 110. A similar method of assigning points is used for fruits, dairy products and meats. A special chapter is devoted to salt substitutes and those which are advertised as such but really contain more sodium than are permitted. The trade names of these pseudo-salt substitutes are given so that the patient may be aware of such deceptive products. The consumer is advised to read carefully labels of supposed low salt items and is warned that certain patent names which do not mention ingredients may contain sodium. An example of this is Mycoban which is either sodium or calcium propionate.

Although not a cook book in itself, in that it does not outline specific diets or suggest salt free recipes, this volume is well worth reading by every patient who takes his salt restricted diet seriously and wishes to avoid the pitfalls of ingesting more sodium than the physician prescribes.

R. D. GOODMAN, M.D.

Physical Examination of the Surgical Patient. By J. Engelburt Dunphy, M.D., F.A.C.S., Associate Professor of Surgery, and Thomas W. Botsford, M.D., F.A.C.S., Clinical Associate in Surgery, Harvard Medical School. Pp. 326. Philadelphia, W. B. Saunders Company, 1953. (\$7.50)

Successful surgery depends upon accurate diagnosis as much as upon good technic and the ability to arrive at a correct diagnosis results from painstaking, thorough examination. Though experience may be gained with time, in order to get the most out of his clinical material, the well-trained surgeon must be grounded in fundamental principles, which this volume ably presents. The reviewer was favorably impressed by the completeness of this book and the simplicity and clarity of presentation. The authors not only teach the examiner what to look for but also how to interpret his findings. They repeatedly stress the fact that physical findings may be altered if the patient has had antibiotics. The surgeon who is actively engaged in a busy practice may find this volume very elementary but the surgical intern and resident should be happy to have this book handy in the hospital library. It probably will find its greatest use in medical schools as a companion volume to a textbook on physical diagnosis.

HENRY REICH, M.D.

Surgery of the Pancreas. By Richard B. Cattell, M.D., Surgeon, and Kenneth W. Warren, M.D., Surgeon, Lahey Clinic. Pp. 374. Phila., W. B. Saunders Co., 1953. (\$10.00)

This reviewer rarely has found his task as enjoyable and profitable as he did in reading this monograph. The authors' vast experience in diseases of the pancreas makes itself evident through-

out, especially in those pages dealing with the steps of operative procedures.

Although the opening chapters deal with the subject matter with clarity, a clearer method of presenting the blood changes found in the various disease entities is desirable.

The authors bent backward in trying to present in almost every chapter the views of other well-known observers. This tends to be somewhat tiresome and may contribute to the by-passing of some salient points.

The most interesting passages are those dealing with the technical details, especially in chapters four through eight. The written word is aided tremendously by first rate photographs and diagrammatic sketches.

The case reports interspersed throughout the volume are of great interest and serve to highlight many particular individual problems.

This volume should serve as an excellent manual for resident surgeons and those general surgeons who wish to acquaint themselves with the surgical treatment of disorders of the pancreas.

EUGENE V. PARSONNET, M.D.

Peripheral Nerve Injuries; Principles of Diagnosis.

By Webb Haymaker, M.D., Chief, Neuropathology Section, Armed Forces Institute of Pathology, and Barnes Woodhall, M.D., Prof. of Neurosurgery, Duke University School of Medicine. 2d. ed. Pp. 333. Phila., W. B. Saunders Company, 1953. (\$7.00)

This is the second edition of a volume originally published in 1945. The first edition was hailed by reviewers as a valuable addition to the literature on peripheral nerve injuries. The material on which the book is based is primarily derived from the military experience of World War II. In examining this monograph, one is impressed by the richness of the illustrative material. The majority of the photographs and illustrations were obtained from the enormous collection assembled at the Armed Forces Institute of Pathology during World War II and in the course of the recent Korean conflict.

The text is divided into four sections. The first deals with the general principles of innervation, the second with the examination of the patient, the third with the general classification of peripheral nerve injuries and causes and symptoms arising therefrom and the fourth with the clinical features of the individual plexus and peripheral nerve injuries.

Little or no attention has been paid to the question of treatment. This is undoubtedly a wise decision for it is clear on first inspection that this book is dedicated to the subject of form and function, dealing with the anatomy, physiology and function of peripheral nerves and the sequelae of injury. It is undoubtedly the most complete monograph that we have on this subject at present and as such will be of tremendous value to the neurosurgeon or general surgeon who handles injuries of this type.

The volume is well put together, the paper and printing are first class, the illustrations well worked out and in each case adequate. Where photographs are not complete or do not tell the entire story, simple little diagrams are included which tell the remainder of the story.

This volume is recommended without reservation and represents, at this time, our most up-to-date source of information on peripheral nerve injuries.

LEWIS H. LOESER, M.D.

An Atlas of Surgical Exposures of the Extremities.

By Sam W. Banks, M.D., Associate Professor of Orthopedic Surgery, Northwestern University Medical School and Harold Laufman, M.D., Associate Professor of Surgery, Northwestern University Medical School, Pp. 391. Philadelphia, W. B. Saunders Company, 1953. (\$15.00)

As the authors state in the preface, the need for a comprehensive atlas of surgical incisions of the extremities has existed for many years. This beautifully printed, profusely illustrated book is their attempt to answer this need.

The book is divided into eleven sections, each representing a different anatomic region of the extremities. Each section contains descriptions and illustrations of numerous surgical approaches to the particular region under consideration. The illustrations as presented in the atlas were arrived at by original dissections, photographs, rough drawings from the photographs, and final drawings. The atlas was designed primarily to serve the student and resident in surgery. Every effort has been made to make the illustrations anatomically correct.

All of the illustrations are done in various shades of gray. Because of this lack of contrast, the anatomic structures are difficult to differentiate and the operative procedures hard to follow step by step. If the illustrations were done in greater contrast or color, the atlas would be much easier to use and its overall value enhanced. As it now stands, it can best be used only in conjunction with an anatomic dissection or good atlas of anatomy.

LEONARD HARRIS, M.D.

Atlas of Regional Dermatology. By Ernest K. Stratton, M.D., Research Associate, University of California Medical Center. Pp. 288, Springfield, Ill., Charles C. Thomas, 1953. (\$15.00)

Most textbooks of dermatology arrange their subject matter in morphologic or etiologic grouping. However, the distribution of an eruption is an important guide to diagnosis, particularly for one not expert in recognizing individual lesions. Hence, there is an advantage in presenting the subject matter in this atlas according to the part of the body affected. This method is not new, for Sabour-

aud wrote his "Elementary Manual of Regional Topographical Dermatology" half a century ago, and Epstein published his "Regional Dermatologic Diagnosis" a few years back in this style.

Except for six pages of color reproductions, the illustrations are in black and white. However, they are excellent half-tones portraying well the depth and texture of the skin conditions. For the most part, the individual pictures are well chosen and arranged to show the similarities and differences of various disease processes affecting identical portions of the body.

The explanatory text, as in most atlases, is rather brief; space devoted to etiology and treatment is often short and dogmatic. Thus, in the discussion of lichen urticatus, no mention is made of the important role of insect bite allergy. A common entity, nummular eczema, is not mentioned but is illustrated under the title eczematoid dermatitis. One photograph is captioned "Pick-Herxheimer Disease," an eponym which might tax the memory of even the most erudite dermatologist.

The section on leprosy, written by Dr. Arnold of Hawaii, is one of the most up-to-date expositions of the subject in a modern dermatologic text.

This volume can be recommended to the practitioner or specialist who enjoys pictorial presentation and realizes both the advantages and limitations inherent in an atlas.

WILLIAM SNYDER, M.D.

Science and Man's Behavior. By Trigant Burrow, M.D. Pp. 564. New York, The Philosophical Library, 1954. (\$6.00)

In 1947, the late Trigant Burrow completed his monograph on "The Neurosis of Man." This 400 page essay is now reprinted within the covers of this volume. Also included is a 90 page report, "The Science of Man's Behavior" analyzing letters from 29 outstanding human scientists. This report was prepared by sending selected parts of "The Neurosis of Man" to the scientists and then evaluating the answers. This section of the book was started by Dr. Burrow and, after his death, completed by William E. Galt, Ph.D. The rest of the volume consists of forewords, glossaries, appendices and indices.

Dr. Burrow's thesis is now well known in American psychiatry. He considers that normal behavior is neurotic. In view of what man is doing to the world today, this could well be true. He demands a science of human relations and offers an introduction to it, which he calls "phylobiology." This constitutes the theme of the book. As with most of Dr. Burrow's work, the language is heavy, the sentence construction is complex, and the thinking is profound. It is a hard book to read. It must be studied. It can be sipped; it cannot be gulped. The thesis is challenging, unpopular, thought-provoking, and, for all I know, it may even be correct.

HERBERT BOEHM, M.D.

Supplied by New Jersey Trudeau Society

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

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No. 2

Streptomycin and Dihydrostreptomycin

Editorial, The New England Journal of Medicine, June 18, 1953. (Reprinted with slight revision by the author.)

In 1946 it was reported that streptomycin salts may be reduced to form corresponding dihydrostreptomycin salts which were more stable in alkaline solution and had other desirable chemical properties. Subsequent reports on the comparative activity of streptomycin and dihydrostreptomycin, both *in vitro* and *in vivo* showed that on the whole the drugs were equally active, although against a number of bacterial species, including some strains of tubercle bacilli and of salmonella, dihydrostreptomycin was appreciably less active.

In the November, 1948 issue of the *American Review of Tuberculosis* a series of six separate reports on laboratory and clinical aspects of dihydrostreptomycin appeared. Among them were two clinical reports, one on 14 patients treated at the Mayo Clinic and the other concerning 12 patients observed at the New York Hospital. The investigators in both clinics concluded that dihydrostreptomycin seemed to be as effective as streptomycin and had the advantage of being tolerated longer before toxic manifestations became apparent. The other important feature noted was the fact that dihydrostreptomycin could be used to continue therapy in some patients who had shown sensitivity reactions to streptomycin. Although these workers were satisfied that dihydrostreptomycin was an improvement over streptomycin in this regard, both groups emphasized the fact that its administration in sufficiently large doses could produce the same damage to the nervous system as streptomycin. A major drawback to large-scale use of streptomycin is the emergence of drug-

resistant strains of tubercle bacilli and this was not overcome by the derivative; moreover, cross-resistance between the two agents was complete.

In spite of the small number of cases and the short period of the study, these observations had such a profound effect on many tuberculosis clinics and general hospitals that they rapidly turned from streptomycin to the use of dihydrostreptomycin. Within a short time nearly 90 per cent of all streptomycin that was produced and distributed was in the form of salts of dihydrostreptomycin.

It was not long, however, before workers began to realize that dihydrostreptomycin was not as innocuous as the early reports had led them to expect; indeed, that its potential toxicity was fully as grave as that of streptomycin. Although the toxic effects of dihydrostreptomycin on the vestibular apparatus were less than those of streptomycin, severe damage to the auditory nerve with permanent loss of hearing and even complete deafness were far more frequent, particularly when intensive and prolonged therapy was employed. These complications led several observers to recommend that dihydrostreptomycin be used only with patients who had become sensitized to streptomycin.

A more controlled study of the comparative toxicity and efficacy of the two forms of streptomycin was made by the workers in the hospitals collaborating with the Veterans Administration's study on the chemotherapy of tuberculosis. Data in groups of patients treated in exactly the same manner but given either streptomycin or dihydrostreptomycin, the choice of agent being entirely by a random selection, were presented at the Eleventh Conference of Chemotherapy of Tuberculosis in January, 1952. The study indicated that dihydrostreptomycin and streptomycin were

equally effective and equally toxic, but whereas streptomycin was somewhat more toxic to the vestibular apparatus, dihydrostreptomycin caused more auditory damage and perhaps slightly fewer hypersensitivity reactions.

At the 12th Conference, in February 1953, Lyght and Hawkins reported on another controlled study of the efficacy and toxicity of these two agents. They found both to be about equally effective. Streptomycin apparently produced a higher percentage of sputum conversions, caused more allergic reaction, and frequently was significantly toxic for the vestibular system. Dihydrostreptomycin was relatively well tolerated with respect to allergic reactions, seldom was toxic for the vestibular system but was more likely to cause auditory loss which was sometimes progressive, especially after prolonged therapy.

Two other studies dealing with the combined use of streptomycin and dihydrostreptomycin, were reported at this conference. A laboratory study, by Poutsiaika, Thomas, Linegar and Hobson, dealt with ataxia in cats—a delicate test for vestibular function. These tests showed that the time required for ataxia to develop in the cat from either streptomycin or dihydrostreptomycin was inversely related to the dose and that with the same dose it took appreciably longer to demonstrate ataxia with dihydrostreptomycin. When a similar total amount was used as a 1:1 mixture of the two agents, the appearance of ataxia was somewhat delayed over the time required for it to appear when streptomycin alone was used. This finding seemed important enough to warrant clinical trial of the mixture.

Such a clinical trial was reported by Heck and Hinshaw in 110 patients, each of whom was given daily doses of 1 gm. for 120 days; 34 received streptomycin, 34 dihydrostreptomycin, and 42 the 1:1 mixture of the two agents. Vestibular and auditory damage was studied during a six months' follow-up period. Vestibular disturbances were noted in six (18 per cent) of patients treated with streptomycin and in two (6 per cent) of those

receiving dihydrostreptomycin; auditory disturbances were noted in none of the former, and in five (15 per cent) of the latter. All of the 42 patients treated with the 1:1 mixture were free of both vestibular and auditory disturbances.

Although this clinical demonstration appears to be quite striking, it would seem wise to accept the conclusions with caution. The number of patients was not large, and the results, judging from the laboratory experiment, appear to have been inordinately favorable. Further observations in large numbers of cases are necessary to ascertain whether equally favorable results can be obtained regularly, and under different treatment regimens.

In spite of the recent introduction of isoniazid and the demonstration of its effectiveness, streptomycin, either as such or as dihydrostreptomycin is still the mainstay of long-term antituberculosis therapy. Perhaps the most critical situation in which the availability of two forms of streptomycin has proved useful is in patients who have become sensitized to one of these agents. In such patients it has been possible to give the alternate compound without serious reactions and thus permit prolonged therapy. The hazard of sensitizing patients to both agents must be seriously considered and weighed.

Daily doses of streptomycin were used in the reported studies, perhaps in order to obtain comparable effects. Such doses are no longer considered necessary or desirable except possibly for short periods when chemotherapy is being instituted in acutely ill patients or in preparation for surgery. The most desirable and acceptable regimen for long-term therapy employs streptomycin twice a week with para-aminosalicylic acid daily. With this regimen the incidence of both vestibular and auditory disturbances from either form of streptomycin is low. This removes another cause for seeking to confuse chemotherapy by the use of the combined agents, each of which has certain distinct properties that it may be desirable to invoke separately in critical situations.

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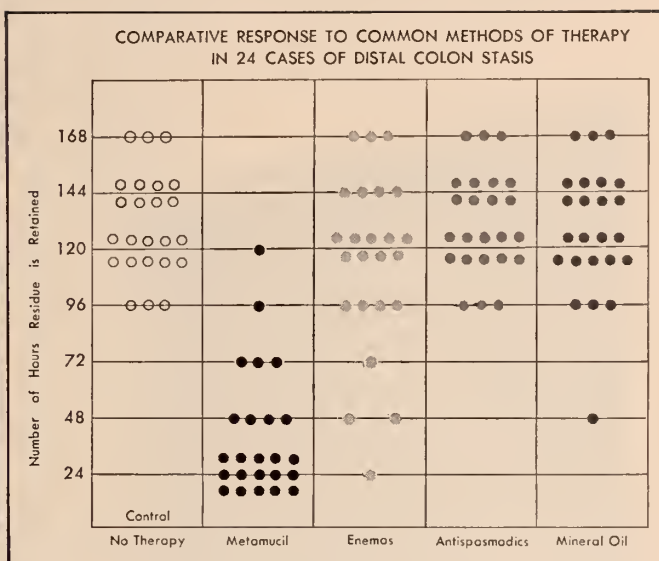
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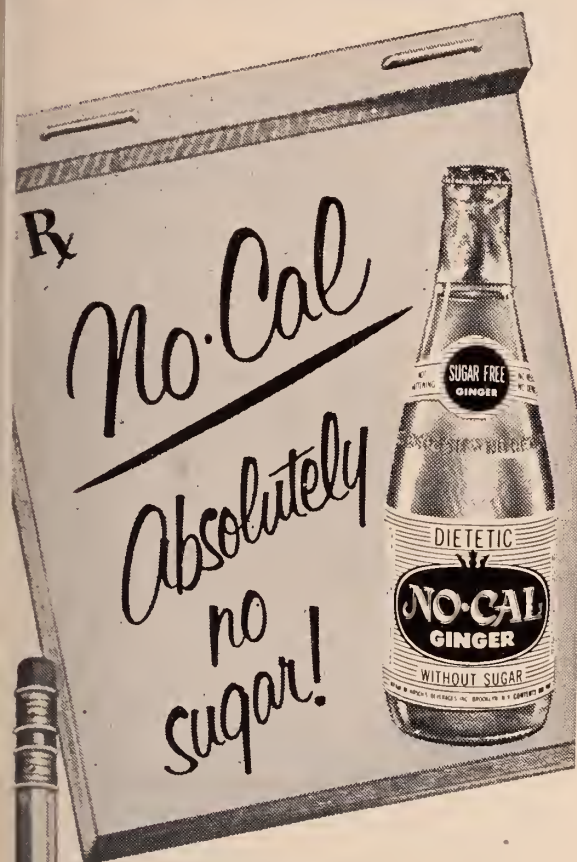
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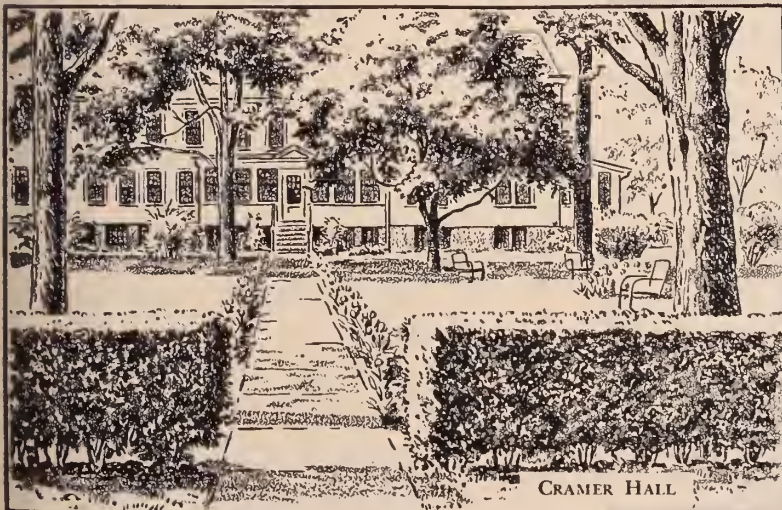
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OF

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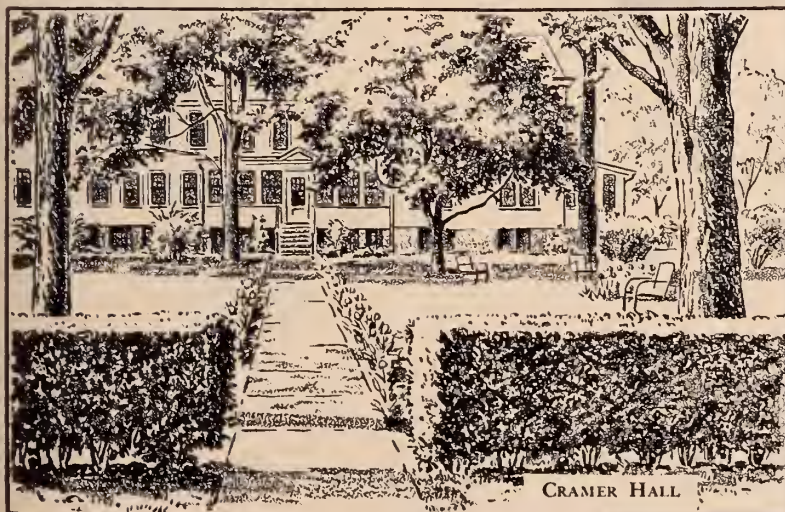
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1. Kauntze, R., and Trounce, J.: Treatment of Arterial Hypertension with Veriloid (*Veratrum Viride*), *Lancet* 2:1002 (Dec. 1) 1951.
2. Wilkins, R.W.: Combination of Drugs in the Treatment of Essential Hypertension, *Mississippi Doctor* 30:359 (Apr.) 1953.

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*Stead, E. A., Jr., in Cecil, R. L., and Loeb, R. F.: Textbook of Medicine, ed. 8, Philadelphia, W. B. Saunders Co., 1951, p. 1065.

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1 English, A. R.; Plan, S. Y.; McBride, T. J.; Gardocki, J. F.; Van Halsema, G., and Wright, W. A.: *Antibiotics Annual* (1953-1954), New York, Medical Encyclopedia, Inc., 1953, p. 70.

2. Finland, M.: *Brit. M. J.* 2:4846 (Nov. 21) 1953.

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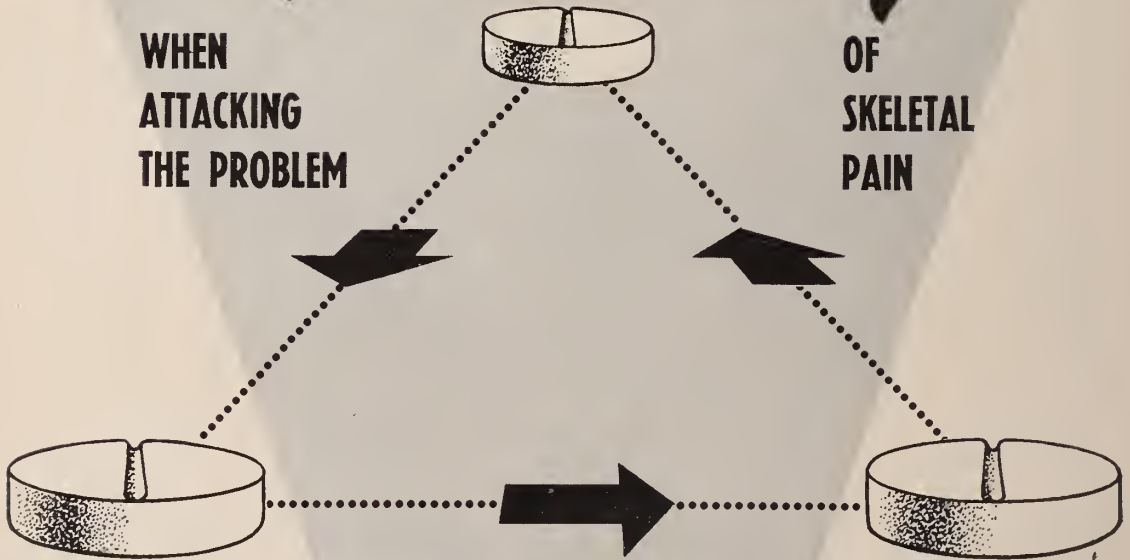
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1. McLester, J. S., and Darby, W. J.: *Nutrition and Diet in Health and Disease*, ed. 6, Philadelphia, W. B. Saunders Company, 1952, pp. 287-299.

2. Pollack, H., and Halpern, S. L.: *Therapeutic Nutrition*. Prepared with Collaboration of the Committee on Therapeutic Nutrition, Food and Nutrition Board, National Research Council, Publication 234, 1952, p. 56.

3. Cecil, R. L., and Loeb, R. F.: *A Textbook of Medicine*, ed. 8, Philadelphia, W. B. Saunders Company, 1951, p. 634.

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1. Sayer, R. J., et al.: Am. J. M. Sc. 221:256 (Mar.) 1951.

2. Welch, H.: Ann. New York Acad. Sc. 53:253 (Sept.) 1950.

3. Werner, C. A., et al.: Proc. Soc. Exper. Biol. & Med. 74:261 (June) 1950.

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5. Potterfield, T. G., et al.: J. Philadelphia Gen. Hosp. 2:6 (Jan.) 1951.

6. King, E. Q., et al.: J. A. M. A. 143:1 (May 6) 1950.

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Glazebrook, A. J., Brit. M. J.,

2:1328, (Dec. 20) 1952.

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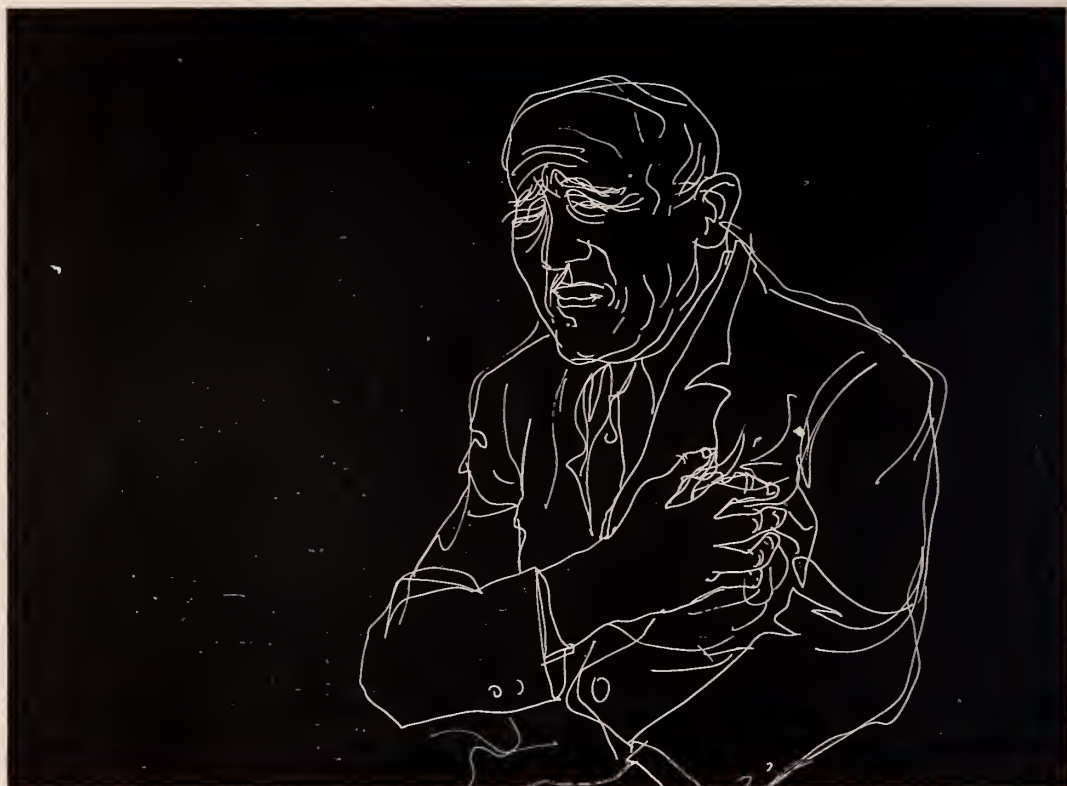


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Available in 10 mg. tablets in bottles of 100, 500 and 5000.

1. Russek, H. I.; Urbach, K. F.; Doerner, A. A., and Zohman, B. L.: J.A.M.A. 153:207 (Sept. 19) 1953.
2. Humphreys, P., et al.: Angiology 3:1 (Feb.) 1952.
3. Plotz, M.: New York State J. Med. 52:2012 (Aug. 15) 1952.

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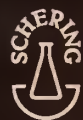


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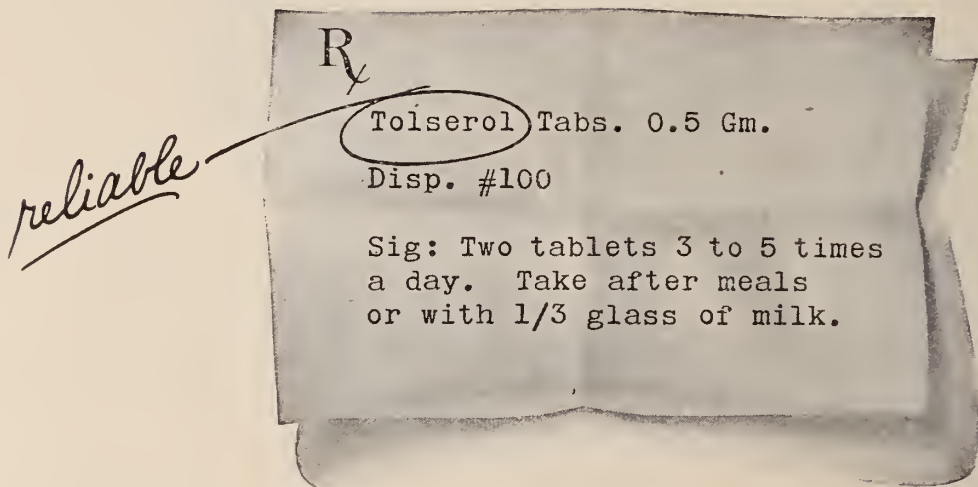
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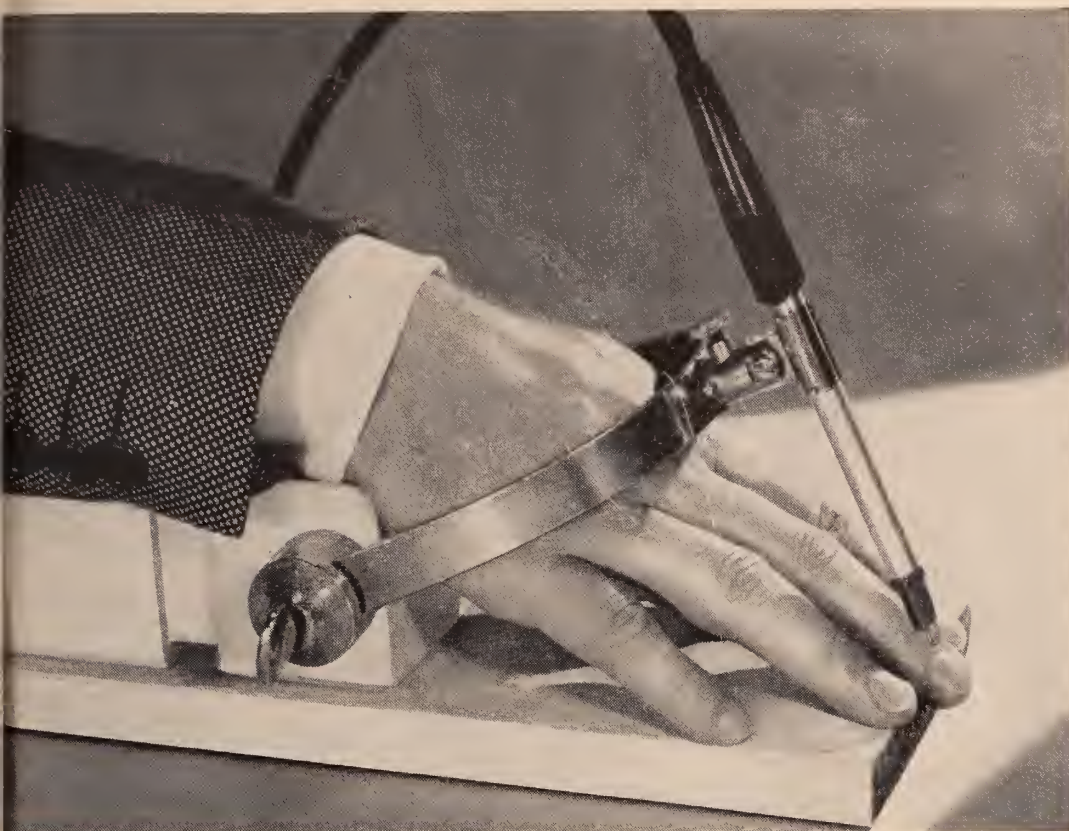
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100 mg. of 'Ilotycin' (as the ethyl carbonate)
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Thirty-pound child: One teaspoonful every six
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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Auto Safety: Who—Me?

Physicians spend much time in their automobiles and in caring for victims of automobile accidents. They are, therefore, vitally interested in auto safety. The increase in the number of automobile accidents, injuries and fatalities is alarming and is a source of concern to state governments, traffic control experts, the police, and insurance companies. The Travelers Insurance Companies of Hartford each year publish a booklet on highway safety. The nineteenth edition of this series, entitled *Who-Me?*, is a 28-page pamphlet illustrated with entertaining cartoons and providing information concerning the causes of auto accidents.

In 1952, 37,600 persons were killed by automobiles compared to 37,100 in 1951. However, in contrast to this record is the fact that over two million people were injured by cars in 1952, an increase of 6 per cent over the previous years. As before, exceeding the speed limit was the major cause of fatalities and injuries. Others are driving on the wrong side of the road and where one does not have the

right of way. For pedestrians, jaywalking or crossing between street intersections was the chief site of death and injury.

The late afternoon and evening hours are the most dangerous times, for then the driver is fatigued, his reflexes are dull and he is often impatient and angry. The hours of one to six a.m. were also marked as those of peak accident rate.

Persons below the age of 25 constitute 15 per cent of all drivers. However, they were involved in almost 25 per cent of last year's fatal accidents. Why do these young drivers cause so many more than their share of accidents? Too many of them do not know how to drive safely. They need competent training and must be taught technics of proper operation and control of automobiles. They must learn traffic laws and the limitations and dangers inherent in driving. A feeling of responsibility should be instilled in these youngsters to avoid their becoming involved in accidents which may mar their lives for many years to come.

Statistics provided by the Travelers Insur-

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Under the Direction of the Committee on Publication

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Whole Number of Issues 595

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ance Companies indicate that most accidents occur in clear weather and on dry roads, when drivers are tempted to relax and drive beyond legal speed limits. More than three out of four accidents in 1952 occurred when roads were dry and the weather good. The experience or sex of drivers involved in accidents has little relationship to involvement in accidents. Drivers of trucks, taxis and buses have a far lower accident rate on a mileage basis than the average passenger car driver. This is because professional drivers take their jobs seriously, know exactly how to steer and brake, how to take care of their vehicles and how to avoid trouble.

The condition of the automobile itself has little to do with causing accidents. In both fatal and nonfatal cases 95 per cent of the autos were in apparently good condition at the time of the accident. The automobiles themselves are not reckless, thoughtless or inatten-

tive. The driver must assume this responsibility.

The most dangerous direction to be driving an automobile is straight ahead. This accounted for about 80 per cent of accidents in the past two years. It is the straight stretch of road, unfettered by heavy traffic or lights, that again tempts the driver to excessive speed and serious accidents. Furthermore, as may be expected the most dangerous days of the week are Saturdays and Sundays. Forty per cent of deaths and 36 per cent of injuries occurred on weekends in 1952.

Copies of this illuminating and educational booklet may be obtained from Mr. John G. O'Brien, Public Information Department, The Travelers, Hartford, Conn. A few copies of these pamphlets judiciously placed on the waiting room table of every physician may contribute to the reduction of automobile accidents in our state.

Fibrocystic Disease of the Pancreas

The management of congenital fibrocystic disease of the pancreas with pulmonary involvement is one of the most difficult problems for the pediatrician. The disease is characterized by striking variations in its severity and its treatment is usually of long duration.

First evidence¹ of this disorder begins a few weeks or a month following birth with the development of a cough. This usually progresses during the next several months and is often spasmodic, resembling pertussis. Clubbing and cyanosis of the nail beds may develop and, although the appetite is normal, weight gain and growth are slow. There may be as many as six daily stools which are mushy and foul and larger than normal. Frequent straining and the size of the stool often result in prolapse of the rectum. Gradually the typical picture of the celiac syndrome develops: scanty subcutaneous fat, a protruding abdomen, muscular wasting, clubbing of the fingers and toes and cyanosis of the nail beds. Abdominal veins are often

conspicuous. As the patient grows older the chronic pulmonary manifestations increase in severity. Bronchopneumonia often predominates and hospitalization is required to save the patient's life.

In a small percentage of patients the pancreatic secretion, which is thick and tenacious, results in the formation of meconium causing obstruction of the bowel (meconium ileus). If evidence of intestinal obstruction appears shortly after birth one should always suspect this condition. Severe widespread lung disease may produce a rapid demise within a month after birth regardless of treatment. On the other hand, some patients show little evidence of the disease even after many years, because of only minimal pulmonary involvement.

Meconium ileus with intestinal obstruction requires prompt surgery in the newborn for the removal of the tenacious viscid meconium. Duodenal intubation to obtain pancreatic juice for enzymatic analysis should be done on patients well enough to undergo this test. The

1. Jones, J. A.: Congenital Fibrocystic Disease of the Pancreas. Penn. M. J., July, 1953.

findings will indicate reduced secretion of trypsin, lipase, and amylase.

Patients with minimal pulmonary involvement can be treated in the home and office. The gastro-intestinal manifestations may be controlled by a diet rich in protein and with about one half the usual fat intake. Any respiratory infection must be treated vigorously to avoid chronic pulmonary disease. In patients developing crises hospitalization is advised. It is important to establish the diagnosis so that the family can be informed of the complexities and seriousness involved.

Very ill patients require oxygen, intravenous medication, antibiotics and good nursing care. Bronchoscopy with aspiration of the tenacious material from the pulmonary tree may be life saving. A careful study of the bacterial flora is indicated so that appropriate antibiotics may

be given. The diet for such severely ill patients should contain twice the average requirement of protein and simple sugars with a total caloric intake of 170 to 180 per kilogram daily. Essential vitamins should be given in three times the normal dose. If the patient can tolerate oral medication, Aureomycin® or Terramycin® has been found the most effective. Pancreatin or violcase improve the digestion of some patients and should be given a clinical trial.

Antibiotic therapy should be continued, with studies made of the bacterial flora every month to avoid administering drugs to which the organisms have become resistant. A warm, dry climate usually improves the prognosis and general health.

By following this course of management the life of a patient with this disease may be prolonged and made more comfortable.

Safety for Nurses

Today's acute shortage of nursing and other auxiliary hospital personnel makes it mandatory that the contribution of these persons not be impaired by accidents and injury. The practicing physician, making his daily hospital rounds, gives little thought to the opportunities for accidents which exist in the average hospital. Accidents to nurses not only cause serious injury and disability but impair the overall efficiency of the hospital as a whole.

Carner,¹ has recently described the sources of accident in a hospital and preventive measures for their correction. She points out that nurses are involved in a higher number of accidents than workers in manufacturing, shipbuilding, aircraft, sheet metal or steel plants. Each year thousands of nurses' hands, fingers, arms, trunks, legs, heads, feet, eyes and toes are injured. These injuries arise from lifting, cuts, bites and blows from patients, foreign bodies, collisions, falls on wet floors, obstructions in hallways or stairways and disease. Industry has long recognized the presence of existing hazards and has developed a program

to prevent accidents. Safety programs in factories are carefully coordinated by the National Safety Council so that safe practice ideas that have been developed by workers in one plant are quickly passed along to other organizations. Combined worker management committees in industry study accidents and work together for prevention.

A similar program is required of hospitals so that accident prevention may reduce the incidence of disability. As a result of such a program the accident rate at the Columbia-Presbyterian Medical Center was reduced 31 per cent during a three-year period.

A coordinated safety program in every hospital is urged. In this way money will be saved, injuries to patients will be reduced, insurance premiums may be cut, absenteeism will be diminished and most important, someone may be saved the pain of an accident caused by lack of knowledge or carelessness.

1. Carner, D. C.: Safety Saves Nurses. *Am. J. Nursing*, Dec. 1952.

RAYMOND A. TAYLOR, M.D.

Lakewood

JESSE SCHULMAN, M.D.

Lakewood

Immediate Gastrectomy in Acute Perforated Ulcer

Persuasive arguments based on experience with sixteen patients, are presented in behalf of immediate subtotal gastric resection in selected cases for acute perforated gastric ulcer.

THIS paper relates our experiences in the surgical management of sixteen consecutive patients with acute perforated peptic ulcer, twelve of whom were treated by immediate subtotal gastrectomy. The period covered extends from November 21, 1949, when our first primary gastric resection for acute perforated peptic ulcer was done, until the present. All patients were operated on by the authors at the Paul Kimball Hospital in Lakewood, a community hospital of ninety beds.

Of the sixteen cases of acute peptic perforation, twelve were treated by primary gastric resection and four by simple closure or excision of the ulcer and closure. There were no deaths in either group.

Prior to November 1949, it had been our practice to treat acute peptic perforations by simple closure of the ruptured ulcer and reinforcement with a tag of greater omentum; or in the case of chronically scarred ulcerations, by excision and simple closure. Stimulated by repeated enthusiastic references in the surgical literature to European surgeons who were doing primary resections successfully, it was decided to try what has now become the pro-

cedure of choice, unless definite contraindications exist.

All sixteen patients were males, and all had symptoms of chronic, recurring indigestion; there were no patients in whom there was a relatively short "ulcer" history leading directly to acute perforation.

Of those patients treated by primary gastrectomy, the average age was 49, with a range of 26 to 69. Of those patients treated by simple closure, the average age was 51, ranging from 40 to 74.

In most cases, the interval between perforation and operation was short, but in no case was this a factor in determining the type of surgical treatment.

Patient number three was hospitalized for four days prior to operation with apparent intermittent leakage. An attempt was made first to treat him conservatively by continuous gastric suction, large doses of antibiotics, and pain control. The patient's general condition improved markedly with this regimen, but he continued to show evidence of leakage and was operated on the fifth day of hospitalization.

Patient number four was a 69-year old man who remained at home with symptoms of acute perforation for forty-eight hours before seeking treatment. He had a large perforation on the anterior aspect of the pyloric antrum with considerable peritoneal soiling. Despite this, a subtotal gastrectomy was performed, and the patient made an entirely uneventful convalescence.

Patient number eight had symptoms of acute perforation for seventy-two hours prior to operation; a large, 0.5 cm. diameter duodenal perforation and extensive peritoneal soiling were found. He, too, made an uneventful recovery following subtotal resection. In all, of the twelve patients subjected to subtotal gastrectomy, four had histories and findings that led us to believe that the perforation had been present for fifteen hours or more. In the group treated by simple closure, the duration of symptoms of acute perforation were two hours, nine hours, twenty-four hours, and four hours.

TYPES OF ULCERS

OF THE sixteen patients treated, ten had chronic duodenal ulcer with perforation; three had single gastric ulcers which had perforated; one had multiple gastric ulcers, one of which had perforated; and two had gastrojejunal perforations. Three of the four patients with gastric ulcer were treated by subtotal resection. Both patients with gastrojejunal perforation were likewise treated by gastrectomy.

Patient number nine had a high, small gastric ulcer which had perforated. Despite the fact that he was only forty-two years of age his general condition was such that it seemed advisable to do simple excision and closure rather than a more extensive operation. Two patients had a history of recent melena together with perforated duodenal ulcer, and both were treated by subtotal gastrectomy.

Two patients had gastrojejunal ulcerations which had perforated. Patient number six was a forty-six year old man who had ulcer symptoms for twenty years and had had a gastro-enterostomy done elsewhere. The operation was done for intractable pain, but it gave him

only temporary relief. This patient was treated by immediate subtotal gastric resection utilizing the former site of the gastro-enterostomy for the jejunal anastomosis. Because this left a long afferent loop, the procedure was augmented by an entero-enterostomy about six inches below the new gastric stoma. Patient number eleven was a forty-one year old man who had ulcer symptoms for ten years and three previous operations; one of these had been a gastro-enterostomy, and another an operative procedure for acute perforation, presumably simple closure. This patient was operated upon within two hours of his acute perforation and a high, subtotal gastric resection performed. In this case, because of the rather extensive adhesions, the peritoneal soiling was well localized.

One other patient, patient number one, had a history of previous perforation and he was also treated by primary gastric resection. Despite the previous surgical procedure, he had extensive peritonitis from a relatively large, anterior wall duodenal opening, but his convalescence was quite uneventful.

INCIDENTAL PATHOLOGIC FINDINGS

TWO of our patients presented unusually interesting incidental pathologic findings. Patient number seven was a fifty-four year old man with a history of indigestion for three years. He developed symptoms of acute perforation and was operated on twenty hours following their onset. At operation, a large perforation along the lesser curvature of the stomach near the pylorus was found. There was also considerable thickening of the pylorus and a moderate amount of pyloric obstruction. Subtotal gastrectomy was performed and the pathologist reported the presence of a benign adenoma of the pyloric antrum which had produced the thickening and partial obstruction noted at operation. The ulcer was just proximal to the tumor. Patient number twelve was a seventy-four year old man who had a large anterior duodenal perforation of nine hours' duration and generalized peritonitis. He had extensive chronic inflammatory change of the pyloro-duodenal area with marked pyloric

stenosis. Also found at operation—its presence had not been previously known—was an intrinsic mass of the descending colon, just distal to the splenic flexure. This mass measured about two by one and one-half inches.

The primary operation on this patient was excision of the perforated duodenal ulcer and posterior gastro-enterostomy. On the fourteenth postoperative day the mass of the descending colon was removed. Resection with primary anastomosis was performed and the mass proved to be a fungating adenocarcinoma of the colon, grade 2. This patient made a relatively uneventful convalescence following both procedures, and left the hospital nineteen days following the second operation.

Of the four patients not subjected to primary subtotal gastrectomy, the considerations were: the state of shock, the general health of the patient, the type of operation desirable, and the surgeons' and anesthetist's opinion as to whether or not the longer procedure could be readily tolerated. For example, in patient number twelve, it was felt that gastrectomy was not indicated because the patient was seventy-four years old with chronic duodenal ulcer and pyloric obstruction. We assumed that his gastric acidity would be low, and felt that gastro-enterostomy was sufficient and represented a truly definitive procedure. The ulcer perforation was therefore closed and gastro-enterostomy done.

TECHNIC

THE type of gastrectomy performed in all cases was the Hofmeister modification of the Billroth II procedure with a short jejunal loop brought up behind the colon. After the stomach has been transected at the selected level, a portion of the gastric opening, from the lesser curvature laterally, is closed to make a gastric stoma of proper size for anastomosis. We have adapted the Furness clamp to this purpose, dividing the stomach along the clamp and then using the pin for traction while closure of part of the stomach is done over the pin. The pin is then removed, and an open anastomosis with the jejunum performed.

Duodenal stump closures were done in the

usual manner, and in none of our cases was drainage employed except in the wound itself. Average operating time for those cases uncomplicated by previous gastric surgery was ninety minutes. The operating team includes a competent anesthesiologist; also, available in the hospital are the facilities of a small but active blood bank and competent laboratory and nursing personnel.

Postoperative treatment was the same as for elective gastrectomy, except that antibiotics were routinely given and in large doses. These were usually begun with the administration of 500 milligrams of Aureomycin® in the intravenous fluids in the operating room and continued for forty-eight to seventy-two hours, or until intravenous therapy was stopped. At this time, a switch to penicillin and streptomycin was made, or antibiotic therapy was discontinued altogether. In the two patients who developed postoperative wound infection, oral Aureomycin® was administered later in the postoperative period.

Our patients used the nasogastric tube with Wangenstein suction for about forty-eight hours, at the end of which time castor oil is instilled via the tube and it is withdrawn. They are ambulant on the first postoperative day, and are encouraged to be active thereafter. Sedatives and narcotics are kept at a minimum, and diet is given as tolerated and desired by the patient. Vitamins are used routinely, with blood and other supportive measures as necessary.

DISCUSSION

THE surgical treatment of acute perforated peptic ulcer is today a controversial subject and one which is in a state of flux. The desirability of doing immediate subtotal gastrectomy for perforated peptic ulcer is a point that could be argued and easily won, even with those most vigorous opponents of primary resection. Reported recurrence rates of 40 to 60 per cent following simple closure would make the statement that "perforation is proof of the intractability of the ulcer diathesis in that patient"¹ seem quite true. And the socio-economic factors involved in subjecting a pa-

TABLE 1. PATIENTS TREATED BY GASTRECTOMY

Patient	Age	Duration of Ulcer Symptoms	Hours Perforated	Ulcer Pathology	Postoperative Stay in Hospital	Comments
JS	35	2 years	5	Chronic duodenal	12 days	Previous perforation 2 years ago; uneventful recovery.
MD	59	20 years	96	Chronic duodenal large	15 days	Failure of attempt at non-operative management with continued leakage.
EWP	69	2 years	48	Gastric	12 days	Uneventful recovery.
GQ	63	Several years	12	Multiple gastric	12 days	History recent melena; uneventful recovery.
FH	46	20 years	15	Chronic gastro-jejunal	13 days	Previous gastro-enterostomy, 4 years, pain re-curred; moderately stormy postoperative course.
TW	54	3 years	20	Gastric	10 days	Uneventful course.
OB	65	Many years	72	Chronic duodenal	10 days	Uneventful course.
RJW	43	3 weeks	2	Duodenal with hemorrhage	14 days	Superficial wound infection, otherwise uneventful.
RB	41	10 years	2	Gastro-jejunal	10 days	Three previous gastric operations including gastro-enterostomy and simple closure; smooth post-operative course.
NW	50	16 years	2	Chronic duodenal	11 days	Advanced Parkinson's disease; smooth postoperative course.
JB	26	2 years	2	Chronic duodenal	9 days	Uneventful course.
WTB	33	2 years	36	Chronic duodenal	8 days	Ulcer sealed by adherence to fundus of gall bladder with intermittent leakage; uneventful course.

TABLE 2. PATIENTS TREATED BY SIMPLE CLOSURE

HT	40	2 years	4	Chronic duodenal	10 days	Uneventful course; general condition dictated choice of shorter procedure.
RJ	42	Unknown	2	High gastric acute	13 days	Poor general conditions at time of operation dictated choice of short procedure despite gastric location.
HH	74	Many years	9	Chronic duodenal large	32 days	Incidental finding of carcinoma of descending colon, operated 14 days after initial operation.
JV	48	Unknown	24	Chronic duodenal	24 days	Postoperative wound infection prolonged convalescence; extreme edema of duodenal area dictated choice of procedure.

tient to the second operation that is almost always necessary if a "cure" is to be effected, are important considerations. No one will deny that it is much more desirable to have one anesthetic risk than two, one convalescent period than two, one hospital bill, one surgeon's fee, even one episode of psychic trauma than two.

IT SEEMS to us that the only consideration left for argument is "What is the risk?" It is readily admitted that this is the important consideration. Our experience and the reported experiences of many others indicate that with proper selection of patients and with proper consideration of indications and contraindications immediate gastrectomy can be accomplished without increase in the immediate or long-term risk.

Lowden,¹ Auchincloss,² and others have set down the indications and contraindications for this procedure very well. Primary resection is indicated in all cases of acute peptic perforation if the ulcer is chronic and no definite contraindication exists. Such contraindications would be: extremes of age, debility, advanced cardiovascular disease, or other conditions which would contraindicate gastrectomy if the procedure were an elective one. The time interval between perforation and operation is relatively unimportant, since the leakage from the highly acid stomach and first portion of the duodenum is more apt to produce a chemical peritonitis than a bacterial one. This is well demonstrated in those cases of acute perforated peptic ulcer where cultures were taken.³

ONE must assume that this operation will not be undertaken unless a competent and experienced surgical and anesthesia team is available. Auchincloss² points out that it is not enough to compare the mortality rate for elective primary gastrectomy with the mortality rate for other types of treatment for acute perforated ulcer, since the latter includes those patients whose general condition is such that mortality, rather than recovery, is expected.

The mortality rate must be compared with the mortality rate of each particular surgical team in elective gastrectomy. This operation should not be done unless a favorable comparison between the mortalities for primary and

elective resections can be obtained.

Dressel,³ points out that it is the consensus of those who advocate primary resection "that in skilled hands primary resection offers no increased hazard, but, by and large, for the average general surgeon, simple closure is the best, with recurrence handled later as an elective procedure." The following definite indications for primary gastric resection are listed:

1. Perforated carcinoma of the stomach with a delimited resectable lesion.
2. Perforated peptic ulcer with recent or simultaneous gross hemorrhage.
3. Perforated peptic ulcer with fixed pyloric obstruction.
4. Recurrent perforation.
5. Perforation with insignificant soiling.
6. Very early perforation in the young as the majority under age 35 do not remain free of symptoms with simple closure. "The risk is small and the need for a permanent cure and good health is important."

WE WOULD agree with all of these indications except number three—perforated peptic ulcer with fixed pyloric obstruction. It is our feeling that in the elderly patient gastro-enterostomy represents truly definitive treatment for pyloric obstruction; subtotal gastrectomy subjects the patient to needless additional surgical trauma and risk. As illustrated by our patient number twelve, closure and gastro-enterostomy is the operation of choice for pyloric obstruction when the age is such that one can safely assume a low gastric acidity with a minimal risk of gastrojejunal ulcer recurrence.

In our cases, choice of operative procedure was not attempted until the abdomen had been opened and the findings noted. The possibilities were then discussed quickly with the anesthetist who, in the meantime, had been given an opportunity to evaluate the patient's condition under anesthesia with pain eliminated as a factor in the "shock state." In these deliberations, every condition which must be intuitively considered by the surgeon in making decisions at the operating table was weighed. The extent of the peritonitis; its degree of localization; the mobility of stomach and duodenum; the location of the ulcer, whether gastric, duodenal, or stomal, etc., were factors in deciding on the procedure to be done.

SUMMARY AND CONCLUSIONS

SIXTEEN consecutive cases of acute peptic perforation without death, twelve of which were treated by immediate subtotal gastrectomy, are presented and analyzed with special attention to the reasons for the choice of operation in each patient.

It is concluded that immediate subtotal gastrectomy is the desirable treatment for most acute peptic perforations. It is indicated in all cases where the ulcer is chronic and no special condition of age or disease exists which would contraindicate gastrectomy as an elective procedure. We were impressed with the

manner in which those patients selected for immediate gastrectomy withstood the procedure and consider the morbidity to be little different from that for elective operation. Wound infection was the only specific complication encountered.

While the number of patients is admittedly small, it is our opinion that immediate subtotal gastrectomy for acute peptic perforation can be performed safely in selected cases by an experienced and skilled surgical team and that the basis for selection of patients for this procedure is undoubtedly much more liberal than has heretofore been accepted in the United States.

58 Madison Avenue

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Phenylbutazone Fatality

Butazolidin® has been reported to produce the following toxic manifestations: skin rashes, edema, nausea, reactivation of peptic ulcer, anemia, leukopenia, stomatitis, dizziness, nervousness, purpura, gastrointestinal hemorrhage, euphoria, hematuria, thrombocytopenia, and agranulocytosis. Recently two fatalities due to this last named condition following phenylbutazone therapy have been reported.

Nathan,* *et al.* have described a death due to an overwhelming toxic and possible hypersensitivity reaction manifested in the skin and viscera. Their patient, a 60-year old white woman, had had phenylbutazone, 200 mg. four times a day, for nineteen days before she entered the hospital. Two days before admission, although her arthritic pain had subsided, she complained of malaise, weakness, lethargy and enlarged lymph glands. The medication was stopped but the symptoms grew progressively worse and a diffuse erythema developed over the hands and forearms. On the day of admission to the hospital she was acutely ill. She exhibited a general-

ized multiform eruption with urticarial lesions, vesicles and bullae, some of which were hemorrhagic. In spite of intensive therapy with penicillin, vitamins, antihistamines and ACTH her downhill course continued and she died eleven days after admission. At no time did she show evidence of a pancytopenia.

Autopsy revealed the major lesions to be in the heart, blood vessels and adrenals. A non-specific myocarditis was present. The vascular degenerative and necrotic lesions were suggestive of a hypersensitive reaction.

Toxic effects following phenylbutazone are reported in the literature in an incidence ranging from 13 to 44 per cent. In most of these cases discontinuance of the drug resulted in relief of the toxic effect. However in the presently reported case stopping the drug and the use of vigorous counter measures failed to halt the progress of the toxic reaction.

* Nathan, D. A., *et al.*: Death Following Phenylbutazone (butazolidin) Therapy. Report of a Case. *Ann. Int. Med.* 39:1096, November, 1953.

Hemorrhage in Pernicious Anemia*

An unusual case of pernicious anemia presenting epistaxis as the major symptom is reported.

PERNICIOUS anemia is a chronic disease characterized by achlorhydria, macrocytic anemia, megaloblastosis, and neurologic changes. It is a disease of late adult life, more common in males in the United States, and comparatively rare in Negroes.^{1,2} This paper reports an unusual case of pernicious anemia, unusual not only because it was found in a young colored female but also for its atypical manifestations.

CASE REPORT

A 41-year old Negro female was admitted to Newark City Hospital on April 15, 1952. The patient was confused and disoriented the only history available was that for approximately two weeks she had been waking up to find her pillow blood-stained. Her physician requested admission for control of severe epistaxis.

Examination: Temperature 99.2 degrees, pulse 120, respirations 28, and blood pressure 70/50. The skin showed no evidence of rash, petechiae or ecchymoses. The nose showed no active bleeding, but the right nostril was filled with bloody crusts. Conjunctivae were pale; sclerae were not icteric. The heart had a rate of 120, a gallop rhythm at the apex, and no thrills or murmurs. The liver and spleen were not palpable; there was no adenopathy. Neurologic examination showed absence of the patellar and ankle reflexes bilaterally. Position and vibratory senses could not be evaluated because of the patient's confusion.

Admission laboratory studies: Hemoglobin, 1.5 Gm. (9%); red cell count, 390,000; and white cells, 2,250 with 12% polymorphonuclears and 88% lymphocytes. A blood transfusion was started and a sternal marrow aspiration done. This was found

to be megaloblastic, and concentrated liver extract, 15 units daily, was started. Three gastric analyses showed no free acid with histamine.

The next day the patient seemed improved, but on the third day hemorrhage began from the nose and gums, and gross hematuria occurred. Fundoscopic examination revealed recent hemorrhages. Further blood studies disclosed normal bleeding time, clotting time, prothrombin time, and clot retraction. The platelet count was 23,000. The patient was given an additional 500 cc. of blood. Daily blood studies, including the reticulocyte response, are shown in Figure 1 and Table 1. Bleeding from all orifices stopped on the sixth hospital day.

Additional history was then obtained of two previous hospital admissions. In June 1951, the patient was treated at Newark City Hospital for an incomplete abortion, with a hemoglobin of 40 per cent.

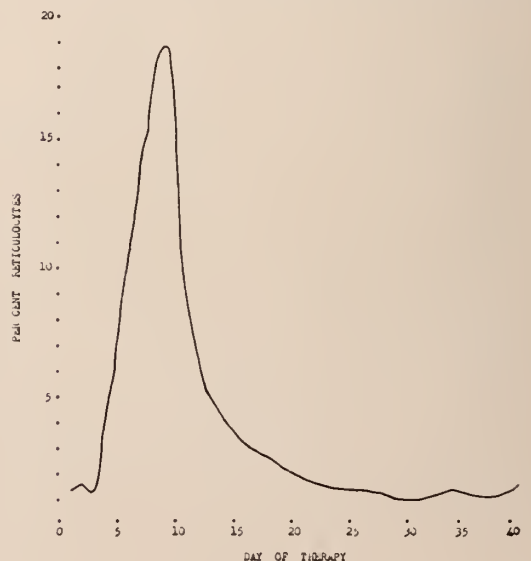


Figure 1. Reticulocyte Response.

* From the Medical Service of Dr. B. Saslow, Newark City Hospital.

[†] Former Resident in Medicine.

	4/15/52	4/16/52	4/21/52	4/29/52	5/6/52	5/26/52	6/23/52
	9%	10%	41%	44%	55%	62%	62%
Hemoglobin	(1.5 Gm.)	(1.7 Gm.)	(7.0 Gm.)	(7.6 Gm.)	(8.5 Gm.)	(9.5 Gm.)	(9.5 Gm.)
Red Blood Count	390,000	520,000	1,360,000	1,760,000	2,380,000	3,100,000	3,230,000
White Blood Count	2,250	2,400		4,900	5,600	5,140	4,250
	P-12	P-27		P-74	P-78	P-84	P-84
	L-88	L-73		L-26	L-22	L-16	L-16
Bone Marrow	Megalo-blastic		More mature			Normal cellularity	
Platelets		23,000			375,000		183,000
Bleeding Time		30 sec.				1 min., 50 sec.	
Clotting Time		5 min., 25 sec.				3 min., 20 sec.	
Clot Retraction		Start-2 min.				Start-9 min.	
Prothrombin Time		Complete-55 min.				Complete-63 min.	
Sickling Kahn		100%					66%
		Negative					
		Negative					
Saline Fragility			*B.H. Control—0.44% Patient—0.40%	*C.H. 0.38% 0.24%			

* B.H.—Beginning hemolysis

C.H.—Complete hemolysis

TABLE 1: LABORATORY STUDIES

She was given 1500 cc. of blood at this time and discharged. No placental tissue was found on laboratory examination, however, and bleeding from the gums was noted. In retrospect, this may have been an episode similar to the current one.

In 1945, at the age of 34, the patient was admitted to another hospital and had a hemoglobin of 35 per cent and a red cell count of 1,460,000. A bone marrow aspiration was reported as consistent with pernicious anemia, and the patient was treated with liver extract for four months before failing to return to the follow-up clinic. During this time no hemorrhagic tendencies were noted.

The patient continued to improve, and re-evaluation showed a normal bone marrow on May 26, 1952 with a platelet count of 375,000. The neurologic diagnosis was subacute combined sclerosis. The patient was last seen on June 23, 1952, at which time she presented the following hematologic picture: Hemoglobin, 9.5 Gm. (62%); red cell count, 3,230,000; white cell count, 4,250; and platelets 183,000. The patient felt well, and there was considerable decrease in the ataxia.

DISCUSSION

A REVIEW of the literature confirms the impression that while thrombocytopenia is common in pernicious anemia, hemorrhages are rare. Biermer,³ in his original description in 1871, mentions a high incidence of retinal hemorrhages and cutaneous petechiae, and also the

occasional presence of marked gastro-intestinal and genito-urinary bleeding. Minot, in 1918,⁵ reported one case of "purpura hemorrhagica" due to pernicious anemia, stating that it is a rare finding, and of serious prognostic import, signifying that the disease has run its course. Held⁴ agrees that bleeding may occur, but other authors do not. Some^{1,6} merely mention the platelet deficiency, while others^{7,8,9} state there is no tendency toward hemorrhage. Hypoprothrombinemia as the cause of bleeding is ruled out by the study of Warner and Owen¹⁰ which showed that the lowest prothrombin level in a series of pernicious anemia patients was forty per cent above the level at which bleeding usually occurs.

In this case the platelets were considerably below the so-called critical level, and it seems a reasonable conclusion that the bleeding was caused by thrombocytopenic purpura secondary to pernicious anemia.

SUMMARY

AN UNUSUAL case of pernicious anemia in a young colored female has been presented, whose presenting symptoms were hemorrhagic.

Studies revealed secondary thrombocytopenic purpura, with pernicious anemia the primary disease. A review of the literature concerning such cases is presented.

196 Roseville Avenue

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Surgery of Aortic Aneurysms

Reporting on their experience with seven cases of abdominal aortic aneurysm, DeBakey and Cooley¹ present convincing arguments for excision of the lesion with or without restoration of blood flow. Pointing out that the survival time of patients with such aneurysms ranges from six months to two years, they stress the urgency for treatment of this condition. The age of their patients ranged from forty-seven to seventy-four years and the aneurysms were considered of arteriosclerotic origin in all but one, which was probably luetic. They feel that neither age nor arteriosclerosis by itself constitutes contraindication to the success of excisional surgery. In their cases the location of the lesions was extremely important. In each one the aneurysm was situated in a segment of aorta below the origin of the renal arteries. In each case it was possible to

occlude the aorta and secure a sufficient margin of its wall just below the renal vessels to permit resection and anastomosis. Five patients had aortography (trans-lumbar aortic introduction of 20 to 25 cc. of 70 per cent Diodrast® or Urokon®). This procedure confirmed the diagnosis and provided more exact information concerning the extent and location of the aneurysm, particularly in its relation to the renal arteries and bifurcation.

In their seven cases there was one death, the patient dying of progressive uremia and secondary hemorrhage on the thirteenth post-operative day. All other patients tolerated the operation well and have shown excellent results.

In two patients aneurysms had been wrapped with polythene film thirteen months and seventeen months before resection. Gross and histologic findings of the specimens in each case cast doubt on the efficacy of this treatment.

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PAUL R. KLINE, M.D.

Trenton

Modern Treatment of Acne Vulgaris

Many factors combine to produce acne vulgaris. This review considers the most important ones and summarizes current therapy.

ACNE vulgaris is a disease about which much misinformation has been disseminated. This ranges from the old-fashioned notion that it is a natural part of growing-up and better left alone to the taboo against x-ray therapy which, unfortunately, is shared by many physicians.

In 1914, Pollitzer¹ reported the incidence of acne to be 7.5 per cent of all the dermatoses in the United States. Although no recent surveys have been made, the incidence in this country is believed to have increased steadily since then. This is evident when one notes the high percentage of acne patients attending skin clinics and medical centers, and the large number of these patients seeking help from their physicians and dermatologists. Although the physical pain and suffering is not great, the mental suffering which this disease produces is marked.

In this paper I should like to present some of the advances made in our knowledge of the disease and to attempt to justify certain treatments, both internal and external. A knowledge of the etiologic factors and local changes in the skin which produce acne form the groundwork for our therapeutic approach.

HORMONES

SINCE this eruption occurs predominantly at puberty, the assumption has been made that acne is due to an endocrine imbalance. However, many influences produce changes in the pilosebaceous apparatus. These factors, whether endocrine, infectious or metabolic, produce the primary comedo; all the other changes which we call acne follow.

Since Saboraud advanced the theory that acne vulgaris is produced by an increase of androgenic substances acting upon the sebaceous apparatus, attempts have been made to correct the suspected imbalance. In the female, Goldzieher² has expressed the view that treatment directed towards suppressing androgen secretion with chorionic gonadotrophin or prolactin may be beneficial. In adolescent males, when estrogen hormone therapy was used, an enlargement of the breasts was often noted, without producing any change in the acne. There also seems to be no agreement as to the effects of hormone blood levels in this disease. Obermayer³ felt that the estrogen imbalance was only indirectly responsible for the development

of acne and that the direct cause was probably a poor utilization of vitamin A consequent to some liver dysfunction.

Following the observation that very large doses of estrogen in experimental animals produced cancer, hormone therapy in acne was critically examined. Becker⁴ states that estrogens can stimulate the formation of ovarian cysts, uterine hyperemia, and thickening of the musculature of the uterus. However, there is no evidence that estrogen therapy in young individuals with acne induces cancer. Becker also found that there was no significant increase in androgen excretion in his patients with acne as measured by urinary levels of 17-ketosteroids.

THE use of endocrines is justified, in the opinion of Way and Andrews,⁵ when satisfactory results are unattainable by common methods of therapy. In a large group of young women they reported good response to hormones in 50 per cent; fair in 22 per cent; and unnoticeable in 28 per cent. They considered that the acne in 58 per cent of their series was largely the result of endocrine imbalance, while other positive factors were involved in the remaining 42 per cent. Klump and Torre⁶ use a vaginal smear technic to determine the necessity for hormone therapy and regulate the dosage according to the character of the smears.

A more recent route for administering hormones, the direct application of estrogen creams, is still of doubtful value. Carefully controlled studies cast doubt on its efficacy. Lunsford⁷ stated that he found no effect of topically-applied estrogen hormones in a vanishing cream base. Shapiro,⁸ on the other hand, reported that a cream containing 2.5 milligrams per gram of sodium estrone sulfate, used in 13 males and 17 females, induced a satisfactory clinical remission in 20 of the 30 thus treated. Treatment for more than six weeks was usually necessary in order to produce these results. Sawicky, Danto, and Maddin,⁹ in a carefully controlled trial, found good results in only 3 of 26 treated patients. Seventeen were observed for six weeks or less.

Although hormones are a valuable addition to the therapy of acne, much work must be

done before a satisfactory scientific regimen can be recommended. I do not believe that hormones should be used routinely in treating acne vulgaris. They should be reserved for selected cases after careful tests have been made.

DIET

ALTHOUGH most of us have given up a rigid scheme of dietary treatment in acne, diet still is recognized as an important factor in influencing the course of the disease. The practice of flatly interdicting "all fats and sweets" has been abandoned by most dermatologists. There is no agreement as to the mechanism by which certain foods produce or aggravate this disease. Although most observers do not agree with Urbach's contention that certain foods and other substances produce an endogenous allergenic effect on the pilosebaceous apparatus, it is generally recognized that certain items in the diet are often a contributing factor. Flood,¹⁰ at the Guthrie Clinic, recommends that the following foods be avoided: milk, milk products, pork, ham or bacon, tomatoes, chocolate, oranges and nuts. Foods rich in iodine frequently have to be eliminated. Iodized salt has been shown to aggravate this disease. Judicious elimination of commonly implicated foods during clinical observation is the best procedure.

X-RAY THERAPY

IN MACKEE'S¹¹ textbook on the use of x-ray and radium in the treatment of diseases of the skin, he stated that "while it is true that the x-rays are the most important and most efficacious therapeutic agent we have for the treatment of acne vulgaris, yet this method of treatment has been and is being abused. The abuse lies in the lack of proper care in the selection of cases, the administration of excessive doses and in failure to recognize and overcome the internal etiologic factors." These statements, made 25 years ago, adequately summarize our present concept with respect to radiation therapy.

When x-ray therapy is administered by a competent dermatologist, it is completely safe.

The skill and judgment necessary for x-ray therapy in acne, in my opinion, should preclude the use of this modality by anyone who has not had adequate training and experience.

Many patients have been told that x-rays are dangerous and produce scarring. In a series of cases, Dr. Gahan and I¹² showed that this was definitely not true. This was done by observing the effects of x-ray in acne cases in which we irradiated only one side of the face. In many instances there was less scarring on the side treated with x-ray than on the untreated side. When x-ray is used by dermatologists, it is safe and does not produce cancer, as was shown in a carefully controlled investigation by Sulzberger, *et al.*¹³ Increased knowledge of the effects of x-rays and other radiations on the human body, rapid advances in technics of application and improvement in x-ray equipment have made this treatment even safer in recent years.

Grenz rays have been reported by Sagher as producing good results in a large number of acne patients. We have been unable to duplicate these results with the recommended technic. However, borderline x-rays have been used for too short a time in this country to evaluate their effectiveness properly.

VITAMINS

FURTHER evidence of the complex pathogenesis of acne vulgaris is found when we observe the effect of vitamins on its course. Various findings have been reported by numerous observers regarding vitamins. Most of these authors have reported that of all the vitamins used, vitamin A has produced the best results. In order to obtain optimum response, it is generally agreed that vitamin A must be used in large doses over a period of several months. The new aqueous forms of vitamin A have been shown to produce more rapid and efficient results than the previously used vitamin A in oil. Smaller daily dosages and shorter periods of therapy are effective when water-soluble vitamin A is used. When the oral use of vitamin A is ineffective, I have found that responses can often be elicited by administering the vitamin intramuscularly. Often, a combina-

tion of oral aqueous vitamin A* with parenteral multivitamins* achieved a maximum response.

CASE REPORT

B. S., a 29-year old female had severe acne since the age of 16. There was some improvement following a course of x-ray therapy in 1949. During 1951 there was a severe relapse. Vi-Syneral Injectable® was given with some improvement, but the condition persisted. In 1952, this patient moved to southern California and, despite continued competent treatment, did not improve. At that time, local therapy with sulfur lotions of various types, hormones, and other measures were used. When she returned in December 1952, examination showed no appreciable change in the acne. Vi-Syneral Injectable® was again given with 50,000 units of vitamin A (Aquasol A®) daily by mouth. After 6 weeks she was given 100,000 units, orally, of aqueous vitamin A (Aquasol A®) daily and 2 cc. of Vi-Syneral Injectable® once each week. Almost complete clearing of the acne was noted after 12 weeks of this combined therapy.

In another extremely stubborn case of acne recently seen, the use of injectable multivitamin solution and aqueous vitamin A resulted in a remarkable improvement after years of failure with all other methods of treatment. In many severe cystic acnes I have been able to produce the same results which have been reported with the use of hormone therapy.

INFECTION

PYOGENIC infection is not a primary factor in the pathogenesis of acne vulgaris, the bacteria acting as secondary invaders. Lynch¹⁴ studied early acne lesions and concluded that the organisms found were not connected with the production of the early lesion. However, once the primary lesion is established, bacterial infection may play a prominent role. For many years I have employed vaccine therapy in cases exhibiting a severe pustular element. In these patients I have found that Toxoid-Immugen® is of more value than autogenous vaccines.

In some stubborn cases of acne with a marked pustular element, antibiotic therapy is of value. Determination of sensitivity to various antibiotics has proved to be of little benefit. The antibiotic should be selected on the

* Aquasol A and Vi-Syneral Injectable were the oral and parenteral solutions used (supplied by U. S. Vitamin Corporation).

basis of clinical judgment. The local use of antibiotics is usually of limited value. Antibiotic therapy, in general, should not be used routinely. When it is indicated, prolonged therapy with large doses is often necessary.

LOCAL THERAPY

MANY patients ask, "Why use local applications in treatment? Why not attack the cause if the cause is internal?" It is difficult for them to understand that various agents and stimuli act on the skin to produce plugging of the follicles and the other manifestations of acne which follow, and that these factors cannot be identified readily and eliminated. A concomitant seborrhea of the scalp may also complicate the acne and prolong the disease on the face and back. Until elimination of the etiologic factors can be accomplished, local therapy must remain an important facet of treatment. The plugged sebaceous glands can be unplugged and the comedones removed by local means. Soap and water used three times daily will certainly help, but other measures are usually required. Sulfur and resorcin have been found by many observers to be the most effective agents. This is attested to by the widespread use of polysulfide lotions.

The disagreeable odor, messy application, and irritant qualities limit the usefulness of this compound. It is also not applicable to the scalp. This requires a separate application for the seborrhea. I have recently been employing, with excellent results, a cream which eliminates most of these objections. Sulfur and resorcinol monoacetate are incorporated in a water miscible cream containing pantothenylol[†] which acts as a healing stimulant. This cream is rubbed lightly into the face, back or chest each evening and is easily removed in the morning. Application to the scalp once a week usually suffices for most cases of seborrhea. This cream has also proved of value in seborrhea involving the ear canal.

[†] RS Panthoderm Cream (pantothenylol with resorcinol monoacetate and sulfur) U.S. Vitamin Corporation, New York.

TREATMENT OF SEQUELAE

PITTING and scarring following acne is a serious problem. At present we have only partially solved this problem, but many advances seem to offer hope for relieving patients of these disfiguring scars. I shall only summarize innovations in treatment. Because of the large number of pits and scars, plastic surgical repair is not feasible. Therefore, various methods of peeling have been devised. The most widely used method is done with a carbon dioxide slush. This has produced marked benefit in many cases. Because the amount of cosmetic improvement with these peeling treatments is usually insufficient, attempts at abrasion of the skin have been made and many successful reports recently presented. Most recent of these is abrasion with sandpaper. This is usually administered to the patient under general anesthesia. In some cases where the pitting is deep, the results fall short of the patient's expectation. More recently, a technic of applying a wire brush without general anesthesia and anesthetizing the skin with ethyl chloride before it is used has been reported. Longer observation will be required before a critical evaluation can be made of these two methods of treatment.

SUMMARY

ACNE vulgaris is produced by many etiologic factors. Some of these are internal and some external. It seems logical to conclude that with our present knowledge of this disease, treatment must be both internal and external. Various agents must be used in combination to produce the greatest improvement. Vitamin therapy is one of the great advances in combating this disease. The topical application of a panthenol cream containing sulfur and resorcinol monoacetate for acne and concomitant seborrheas is discussed. Local hygiene, oral vitamin A and injectable multivitamin therapy, and use of a pantothenylol-resorcinol sulfur cream topically appear to be practical and effective methods of treatment. Hormones and x-rays, properly administered, should be employed in selected cases.

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Pilonidal Sinuses

The proctologic department of the Lahey Clinic* recently completed a survey of the treatment of pilonidal sinuses disease by members of the American Proctological Society.

Among proctologists no single operation or technic can be adopted for all pilonidal surgery. Treatment must be individualized to the patient and the local condition. However, the present tendency is to avoid massive block or excisions with excessive removal of healthy tissue. Such procedures often result in prolonged healing time, disability and frequently disfiguring and painful scars.

It was emphasized that the treatment of a pilonidal sinus is not a minor surgical procedure. On the basis of the incidence of this disease and a consideration of the days lost from work it is a major surgical problem.

Failure in the healing of these wounds following a closed technic is due to one of several causes: failure to eliminate dead space, failure to prevent infection or to preserve an adequate blood supply to the area and failure to close such wounds without tension. In addition, trauma must be avoided and the part must be kept at rest during the period of healing.

In open methods of surgery prevention of bridging over the wound or the formation of an excessive amount of granulation tissue must be carried out. Infection likewise must be

avoided. Pilonidal sinuses occur in a region of the body which is difficult to keep sterile and free from moisture and bowel contamination. It is an area with a poor blood supply and is subject to repeated trauma by merely sitting or walking.

The basic principles in successful pilonidal surgery are to keep the area dry, clean and free from infection. Minimal amounts of tissue should be removed. Dead spaces must be eliminated and if the area is immobilized it must be kept free from invaginated hair follicles.

In cases with pilonidal cysts or acute abscesses incision and drainage should be carried out, but such a procedure should be done with consideration of definitive treatment which will be used later.

The majority of those responding to the questionnaire preferred an open type of operation for pilonidal cyst disease with one or more draining sinuses. There was about equal division between simple excision and allowing the wound to granulate in secondarily and the use of a limited excision with post-operative use of cauterizing agents, curetting the wound with dry gauze or a partial closure. A third group used the marsupialization technic. Here the base of the sinus tract is left intact and the skin edges are sutured to the residual scar tissue.

* Swinton, M.D. and Markee, R. K.: Pilonidal Sinus Disease. *Am. J. Surg.*, Nov. 1953.

Surgery in Tuberculous Psychotics*

The modern combined chemotherapeutic and surgical attack on tuberculosis has produced results in psychotic patients which compare favorably with those reported in nonpsychotic patients.

AT THE 1952 meeting of the National Tuberculosis Association, Sommer, Balter, Muendel and Hatch⁸ reported on the treatment of pulmonary tuberculosis in psychotic patients. At that time their best results had been with extra-pleural thoracoplasty. Phrenic nerve operations had been given up as primary procedures because of poor results. Pneumothorax was considered suitable in selected cases while pneumoperitoneum was reserved for patients with extensive bilateral pulmonary tuberculosis. Resectional therapy had been used in only seven patients, but with favorable early results in six living patients. This presentation will discuss the present views of the authors regarding collapse and resectional therapy and the developments of the past year. Further follow-up data on the group of patients treated by thoracoplasty also will be presented.

It should be mentioned that every effort has been made at the two institutions in which these patients have been treated to provide the same therapy for tuberculosis as is given patients in sanatoria for the tuberculous. Com-

bined intermittent antibiotic therapy has been freely used. As a rule, streptomycin, one gram twice a week, and para-aminosalicylic acid, ten or twelve grams daily, have been given. Isonicotinic acid hydrazide has been used largely in combination with the other two drugs. There has been more difficulty in securing patient cooperation in taking para-aminosalicylic acid than with nonpsychotic patients. Isonicotinic acid hydrazide has been substituted, usually successfully, for para-aminosalicylic acid whenever patients have been unable to tolerate the latter drug.

Active programs of detection and isolation have been carried out at the two hospitals for a number of years. At the Veterans Administration hospital every patient has a 14 x 17 inch film roentgen examination each year. Photoroentgenographic surveys are carried out twice each year at the New Jersey State Hospital. Experience has shown the desirability of making such surveys at least twice a year in hospitals for the mentally ill. Admission x-rays are made on each patient at both hospitals. Each patient on the tuberculosis register is examined at regular shorter intervals. At the Veterans Administration hospital practically all tuberculous patients are housed in one unit. This has not been possible at the New Jersey State Hospital, although all active tuberculous pa-

* Presented at the third annual Clinical Meeting of the New Jersey Trudeau Society, Lyons, New Jersey, May 13, 1953. From the Veterans Administration Hospital, Lyons, N. J. and the New Jersey State Hospital, Trenton, N. J.

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[†] Consultant, Thoracic Surgery, V.A.H., Lyons, N. J. and New Jersey State Hospital, Trenton, N. J.

tients are in the building constructed for such patients.

It should be emphasized that treatment programs must be associated with those for the detection and isolation of tuberculous patients. Staff interest cannot be maintained unless progress is being made in the care and treatment of the patients. Without the wholehearted interest and cooperation of the nursing and attendant staffs proper care of the patients with tuberculosis will not be attained.

PHRENIC NERVE PARALYSIS

DURING the past year phrenic nerve paralysis has not been used at either hospital. It will be employed in the future as a complementary procedure with pneumoperitoneum or following lower lobe lobectomy to lessen the volume of the hemithorax and diminish overdistension of the remaining pulmonary tissue.

ARTIFICIAL PNEUMOTHORAX

AT THE time of the earlier report artificial pneumothorax had been started in 74 patients, five of whom had bilateral pneumothorax. During the past year there have been no further pneumothoraces induced. The more general employment of antibiotics has largely contributed to this policy as well as a lack of patients seemingly suitable for pneumothorax therapy. During the past year, two pneumothoraces maintained for 15 and 24 months respectively have been terminated with apparently good results. One of these patients is now on trial visit at home. These two favorable results may be added to the eight good results previously reported, which have been maintained to the present. There have been, therefore, a total of ten good results with pneumothorax. No patients are receiving pneumothorax at present.

PNEUMOPERITONEUM

PNEUMOPERITONEUM has been used in 41 patients with far advanced bilateral pulmonary tuberculosis. In two instances the patients had

had thoracoplasties with activation of lesions in the contralateral lung. In both instances pneumoperitoneum failed; in one the thoracoplasty had been performed elsewhere. In reviewing the results of pneumoperitoneum, more success was found to have been attained than had been suspected. Seven patients have had sputum converted from positive to negative and have maintained their apparently inactive status up to three years following termination of the pneumoperitoneum. One patient has been discharged with an arrested mental condition. Pneumoperitoneum therapy has recently been terminated in another patient with the view of performing a pneumonectomy, which would have been impossible in the patient's earlier condition. At present this form of therapy is being continued in nine patients.

EXTRAPLEURAL THORACOPLASTY

AT THE time of the first report, the best results of collapse therapy had been attained with extrapleural thoracoplasty. In that paper various data regarding the thoracoplasty cases were compared with data from a series of patients treated in a hospital for nonpsychotic tuberculous patients. Although higher rates of complications were present in the psychotic than in the nonpsychotic, the differences were not marked. Follow-up data are presented on the patients with thoracoplasty to bring their status up to date.

In the past year only one additional thoracoplasty has been performed. This poor risk patient with bilateral tuberculosis and emphysema died of paradoxical respiratory movements and spread of tuberculous disease 11 days after operation. In 52 patients two deaths give an operative mortality rate of 3.8 per cent for thoracoplasty. This rate compares favorably with other reported operative mortality rates for thoracoplasty.

There have been one late tuberculosis death and two nontuberculosis deaths following thoracoplasty. One patient has had a lobectomy performed because of a persistent cavity following thoracoplasty; there was roentgen evidence of a good result, but all efforts to secure

sputum or fasting gastric contents have failed due to complete lack of cooperation. The remaining 46 living patients have had repeated examinations of sputum and fasting gastric contents by culture from 8 to 76 months after their operations. The average length of follow-up is 31.5 months and only two patients have been followed less than 12 months (to January 1, 1953); these two patients were followed for 8 and 10 months, respectively, to that date. Tubercle bacilli have been demonstrated from three patients during the past year, in two on one occasion only. In one patient only bronchoscopic sputum specimens could be secured. Forty-three of the 52 patients have had their sputum converted by thoracoplasty (82.7 per cent). There has been sputum conversion in 43 of 47 living patients (92.5%). Roentgenographic studies on all patients are satisfactory except in one patient with demonstrable tubercle bacilli; this patient has a contralateral cavity, resection of which is precluded by rather marked emphysema. The cavity has failed to respond to antibiotics and pneumoperitoneum.

PULMONARY RESECTION

IN THE earlier paper, preliminary results of seven patients whose tuberculous lesions were treated by pulmonary resection were mentioned. Although the results of thoracoplasty, as described, have been very satisfactory, during the past year pulmonary resection has been increasingly employed with only one thoracoplasty being performed. The use of prolonged combined intermittent antibiotic therapy has made pulmonary resection safer for patients and has permitted tuberculous pathology to be controlled so that pulmonary resection becomes the treatment of choice for residual lesions persisting after prolonged antibiotic therapy.

Medlar⁵ has shown that caseation is a constant finding in minimal tuberculosis and that unhealed tuberculous lesions are predominantly present in the superior and posterior portions of the pulmonary lobes. Medlar⁶ and Auerbach, Katz, and Small¹ have shown that in tuberculous pulmonary infections there are foci of pneumonia that do not go on necessarily to caseation. The necrotic foci, however,

do not resolve and either discharge into the bronchi leaving a cavity or remain as caseated foci. These may communicate with a bronchus and, due to slow healing, always present the danger of sloughing. Auerbach, Katz, and Small¹ have shown that with prolonged antibiotic therapy tuberculous cavities greatly diminish in size and their contents often become inspissated. Epithelialization at the bronchocavitory junctions prevents obliteration of the bronchial lumen at this point and is a factor in preventing permanent closure of the cavities. They cite one case in which thoracoplasty failure may have been due to such epithelialization of the bronchocavitory junction.

A REVIEW of the older standard indications for pulmonary resection will not be given here. Chamberlain and Klopstock³ introduced segmental pulmonary resection to eliminate the affected portion of lung and conserve pulmonary tissue. Ryan, Medlar, and Welles⁷ have proposed simple excision of caseous foci after prolonged antibiotic therapy as being more saving of pulmonary tissue than segmental resection. The operation to be performed must be suited to each patient. It must be emphasized that segmental resection and simple excision of residual lesions make possible bilateral pulmonary resection and the successful treatment of patients who previously presented almost insoluble problems. Present practice is to resect sufficient pulmonary tissue to remove cavities and solid caseous lesions, especially those in the posterior portions of the lung. It should be noted that the solid caseous lesions are really inspissated cavities, which still maintain bronchial communication (Medlar,⁶ Auerbach, *et al.*¹). D'Esopo, *et al.*⁴ have shown that after prolonged combined antibiotic therapy acid fast bacilli can be found on smear in the solid lesions, but these bacilli will not grow on culture media or produce tuberculosis in guinea pigs. Bickford, *et al.*² have well stated the case for pulmonary resection and reserve thoracoplasty for patients with cavernous lesions whose general condition or respiratory reserve is not sufficient to withstand resection.

There have been 16 pulmonary resections performed on 15 patients. One patient had bilateral resection with a right upper lobe lobec-

tomy and an excision of a lesion of the left upper lobe. The operations performed were three pneumonectomies, five lobectomies, four segmental resections and four simple excisions of lesions. In three instances of lobectomy or segmental lobectomy smaller lesions in adjacent lobes were simply excised. One pneumonectomy patient died postoperatively. All studies for tubercle bacilli in five of the six living patients operated upon over 1 year ago have been negative. One patient already mentioned has been so uncooperative that bacteriologic studies are not available. One of the patients operated upon recently developed a lower lobe cavity following segmental resection of the right upper lobe and excision of the adjacent portion of the apical segment of the lower lobe; this patient had not had tubercle bacilli demonstrated prior to operation. When the cavity appeared postoperatively and with it tubercle bacilli in the sputum, it was discovered that the patient had not received antibiotic therapy. With antibiotics the cavity has closed. The remaining patients have all had good early results from resection. Fourteen of fifteen patients are living. There have been no postoperative complications of note in the pulmonary resection group except the ipsilateral spread of disease already described.

SUMMARY

EXPERIENCES and practices in the treatment of pulmonary tuberculosis in two hospitals for psychotic patients have been reviewed. In both hospitals standard methods of treatment employed elsewhere have been followed. In the past excellent results have been attained with extrapleural thoracoplasty used in conjunction with rest and antibiotic therapy. At present pulmonary resection is replacing thoracoplasty with excellent early results and a reasonable operative mortality rate. The satisfactory results of treatment of pulmonary tuberculosis in psychotic patients indicate that increasing attention should be paid to this disease in institutions for the mentally ill. Such patients should be concentrated in designated hospitals, which then could provide proper medical, surgical, laboratory, radiologic and anesthesiologic facilities and personnel to treat tuberculosis properly and actively.

The programs of treatment outlined are being continued at both hospitals. An excellent opportunity for evaluating tuberculosis therapy is afforded in these hospitals by long term, closely checked follow-up studies. For instance, one thoracoplasty patient only has been discharged and all resection patients remain in the hospitals.

120 West State Street

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Osteogenic Sarcoma Complicating Paget's Disease of the Femur*

A case of rapidly developing osteogenic sarcoma in a patient with Paget's disease is described.

WHEN an osteogenic sarcoma develops in a person over 50 years of age it should be suspected that one is dealing with a complication of pre-existing Paget's disease. A fracture may be the first sign of malignant degeneration. Constant pain, unrelieved by bed rest, may direct attention to the presence of a sarcoma. It is difficult to estimate the exact incidence of sarcoma in Paget's disease, since the majority of reported cases has occurred in patients with advanced skeletal involvement, and many uncomplicated instances of Paget's disease are not reported. Various estimates of the incidence of this complication have appeared in the literature.^{1,2,3,4} Sarcoma may arise when Paget's disease is restricted to one bone or even to an area of Paget's disease of very limited extent. When a sarcoma appears in one bone, in a case of widespread Paget's disease, other sarcomatous foci are usually present or soon become apparent. The type of malignancy present in Paget's disease is not necessarily an osteogenic sarcoma. Fibrosarcoma,⁵ chondrosarcoma,^{6,7} multiple myeloma^{8,9} and giant cell tumors¹⁰ have been reported in association with Paget's disease. The usual life expectancy after the development of sarcoma is about one year.

CASE REPORT

Mrs. I. K., age 69, was first seen on August 7, 1950. The patient had been entirely well until the

day of admission to the hospital, when she slipped on the floor at home and sustained an injury to her left thigh.

On examination the patient appeared to be in good general health. There was an obvious abnormality in the contour of the left thigh with exquisite tenderness at the site of the deformity. Any attempt to move the left lower extremity was accompanied by pain. Roentgenographic examination (Figure 1a) showed evidence of a transverse fracture of the femoral shaft with over-riding of the fragments.

Laboratory Data: Hemoglobin, 60 per cent; red blood cells, 3,500,000; white blood cells, 11,000 per cubic millimeter, with 70 per cent polymorphonuclear cells. The urine showed one plus albumin and one plus sugar. Chemical studies: Serum calcium, 12.2 mg.%; serum phosphorus 3.6 mg.%; serum alkaline phosphatase 39.5 Bodansky units.

The patient was treated conservatively by means of Russell traction. There was some slight improvement in the alignment of the fragments. The left thigh became increasingly larger than the right thigh. Roentgenographic examination, (Figure 1b) eleven weeks after the trauma, showed that the soft tissues were extensively infiltrated by a dense sclerotic process, extending from the region of the ischial tuberosity distally to the level of the lower third of the left femur. The bone fragments presented areas of rarefaction and sclerosis. Skeletal roentgenograms showed Paget's disease of the left tibia and fifth lumbar vertebra. The circumference of the left thigh was twenty and one-half inches and the right thigh thirteen and one-half inches.

Biopsy examination of the tumor mass was performed on October 21, 1950. Microscopic examination (Figure 2a & b) revealed extensive areas of osteoid tissue. The marrow spaces were filled with spindle cells which varied in size and shape. Mitotic figures were rare. Histologic diagnosis was osteogenic sarcoma developing in Paget's disease. The patient expired on October 28, 1950.

* From the Orthopedic Department, St. Joseph Hospital, Paterson, N. J.

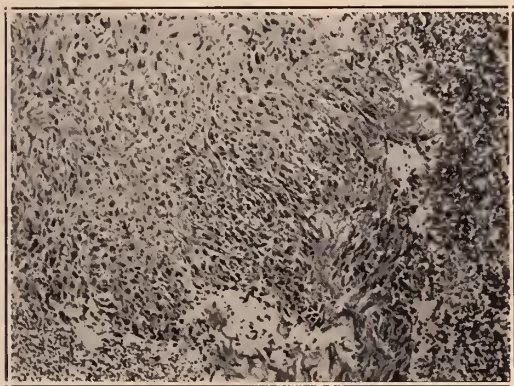


a.

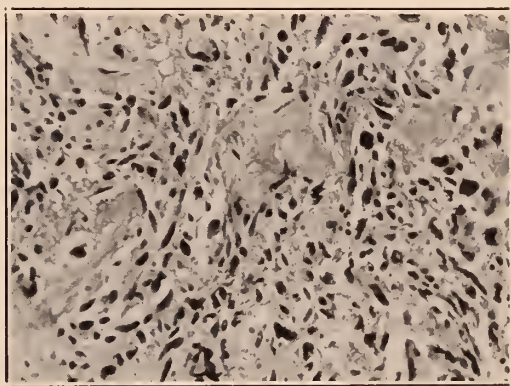


b.

Figure 1. a. X-ray of femur (August 7, 1950). Fracture of femoral shaft in Paget's disease. b. (October 24, 1950). Extensive osteogenic sarcoma developing within three months of fracture.



a.



b.

Figure 2. a. Photomicrograph x 75. Focus of osteogenic sarcoma developing in Paget's disease. b. Photomicrograph x 300. The tumor is composed of spindle cells and tumor giant cells. Note osteoid tissue.

COMMENT

Two aspects of this case are of particular interest: first, it is apparent that a fracture of a bone may so dominate the roentgenogram that radiographic evidence of Paget's disease may be overlooked; second, osteogenic sarcoma, al-

though not recognized even in retrospect on the original x-ray films, may grow so rapidly that within a period of less than twelve weeks extensive sarcomatous degeneration may supervene.

588 East 27 Street

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Thyroid Cancer

Seventy-eight consecutive patients with carcinoma of the thyroid treated at the Lahey Clinic in 1951 and 1952 are reviewed by Cattell and Colcock* in a recent issue of the *Journal of Clinical Endocrinology*. In these two years, 1,479 patients with thyroid disease were operated upon; the overall incidence of cancer was 5.3%. One patient with carcinoma of the thyroid was found in each ten patients with discrete or diffuse nodular goiter.

A clinical diagnosis of carcinoma was made preoperatively in less than half of all cancer patients. There was a high incidence of carcinoma in discrete or solitary thyroid nodules. One hundred and fifty-six patients had this type of goiter. Carcinoma was suspected in only fifteen and found in fifty-two (33.3%).

There are no pathognomonic signs or symptoms of carcinoma of the thyroid in its early stage. Any nodular enlargement of the thyroid gland should arouse the suspicion of malignancy. This is particularly true when the gland has increased rapidly in size or when it is hard and irregular. In fifty-two of the seventy-eight patients with proved carcinoma, a diagnosis of discrete adenoma was made. In only fifteen of these was possible malignancy considered in

the preoperative diagnosis. Diffuse nodular goiter was diagnosed in thirteen cases. Eleven of these were considered non-toxic and only one was suspected of being malignant. Two other patients had diffuse nodular goiter with hyperthyroidism. In eleven patients carcinoma of the thyroid was clinically obvious.

The authors recommend frozen-section facilities at the time of operation in all cases of discrete nodules and, in fact, they should be available for all operations of nodular goiters.

Neck dissection was felt necessary in about half of all patients with thyroid carcinoma operated upon during this two year period. It is indicated in any patient with malignant adenoma who has lymphatic invasion, in all patients with capillary carcinoma and in those with alveolar cell carcinoma. Radical neck dissection with high voltage x-ray therapy postoperatively may improve the end results in the treatment of carcinoma of the thyroid. In one half of all patients in whom neck dissection was performed, the lateral cervical nodes were found to be involved.

In this series of seventy-eight patients there was no operative mortality, but nine patients have already died from malignancy within two years following the operation.

* Cattell, R. B. and Colcock, B. P.: Present Day Cancer of the Thyroid. *J. Clin. Endocrinol.* November, 1953.

Studies in Tobacco Allergy*

After summarizing the literature, material is presented which supports the view that tobacco allergy is a definite clinical entity. The intradermal test with tobacco is critically evaluated.

How valuable is the intradermal test with tobacco smoke or leaf extract in determining who ought to be a non-smoker, preferably before the damage is done?

Rowe¹⁴ believes tobacco sensitization occurs frequently, especially in smokers. Feinberg⁶ says that allergy to tobacco, while not common, is of definite importance and should be considered seriously, even in non-smokers. Tuft¹⁹ reports that tobacco extracts often are irritating and likely to induce non-specific reactions, *probably only a few are specific*. Vaughn²¹ states that one should test with tobacco smoke extract as well as leaf extract. Harkavy, writing in Cooke's⁵ text believes that tobacco causes a specific allergic response.

Pipes¹¹ studied 370 consecutive allergic patients in private practice. About ten per cent gave a definite history of respiratory allergy precipitated or aggravated by tobacco smoke. Forty-seven or thirteen per cent of this group reacted positively to skin tests with tobacco smoke extract. Nineteen of these positive skin tests correlated with a positive history. Ten non-allergic controls gave negative intracutaneous tests with the same extract. Pipes believes that tobacco leaf and smoke extract should both be used in routine skin testing.

HARKAVY⁸ has found eighty-seven per cent of thrombo-angiitis obliterans patients allergic to tobacco extract; only sixteen per cent of con-

trol male cigarette smokers were similarly sensitive. Sulzberger¹⁷ reports over seventy-eight per cent of patients with thrombo-angiitis obliterans reactive to tobacco, against thirty-six per cent among healthy adult smokers and sixteen per cent among non-smokers. Noun¹⁰ says specific sensitivities to tobacco exist in certain patients. Hull¹⁰ tests with tobacco dust and tobacco smoke, and gets frequent one plus reactions. Leney¹⁰ uses an extract of tobacco leaves and feels there is some clinical correlation. Horshman¹⁰ uses tobacco leaf and tobacco smoke extract, and believes tobacco smoke mix has a close correlation with tests and clinical symptoms. Clarke¹⁰ has frequently found positive tobacco tests in patients who were made uncomfortable by being in rooms in which there was tobacco smoke. Stier¹⁰ believes tobacco smoke much more effective than tobacco leaf extract.

Silbert¹⁶ reports a case of angioneurotic edema and thrombo-angiitis obliterans in the same patient who gave a strongly positive skin test to tobacco extract. Upon cessation of smoking the patient was relieved from both conditions. Brown³ reports one per cent of his asthmatic patients reaginically sensitive to tobacco. Green⁷ found that of 100 normal smokers, thirteen per cent reacted to tobacco only, while Trasoff¹⁸ reported seventeen per cent in

* Presented, in part, at the annual meeting of The Medical Society of New Jersey, Allergy Section, May 19, 1953.

forty normal smokers. Harkavy⁸ reports skin testing 100 patients with coronary disease, all smokers. There were forty-four per cent positive skin test reactions to tobacco.

MANY of the above have been able to transfer positive tobacco tests passively; others have failed to do so.

Beck¹⁰ does not find close correlation with tobacco testing and clinical findings, although he reports hay fever and headaches himself when he smokes. Rouse and Kahn¹⁰ do not feel there is sufficient correlation between symptoms and positive reactions to tobacco extract and they feel tobacco sensitivity is an extremely rare condition. Chobot⁴ says that allergy to tobacco is very rare and skin tests are of little value. Shea¹⁰ uses leaf extracts and has had no clear cut cases of allergy to tobacco. Kempster¹⁰ feels tobacco is an irritant rather than an allergen. Irwig¹⁰ agrees. Epstein's¹⁰ experience with tobacco antigen has been disappointing.

Westcott and Wright²³ studied thirty-five cases of thrombo-angiitis obliterans and thirty-five controls and found no higher percentage of positive tobacco skin reactions in the Buerger's disease cases. Trasoff¹⁸ and associates did not find any increase of tobacco reactions in this disease. Bowman, quoted by Coca,² in a study of sixty-nine thrombo-angiitis obliterans patients and sixty normal smokers, found no evidence to indicate that there is a higher incidence of specific cutaneous sensitivity to tobacco in these patients than in normal men. Sheldon, and others,¹⁵ say that the tobacco plant antigen and the tobacco smoke antigen probably are not identical. Waldbott²² reports thirty-one patients with respiratory symptoms from smoking. He found no clear cut correlation of the skin test with asthmatic symptoms. Unger²⁰ believes allergy to tobacco smoke is very uncommon and has had no positive reactions in intradermal testing with smoke extract, using Pipes' method.

Peshkin, writing in Abramson's book,¹ sums up the literature by saying aptly, "The high incidence of sensitization to a well dialyzed solution of tobacco extract by intradermal tests, needs clarification."

IN 1945, I reported the results of tobacco tests on one hundred consecutive asthma patients seen at an Army general hospital. Ninety-eight of these patients were smokers. Using Abbott's tobacco leaf extract, twelve (all smokers) of these hundred patients gave a good positive skin test to tobacco. Cessation or tapering off seemed to result in slight improvement of these twelve asthma patients, probably reducing the irritant effect rather than relieving true allergy. However, one of these twelve positive reactors seemed to have a real allergy to tobacco. His asthma disappeared completely when he stopped smoking and asthma could be reproduced by smoking.

In 1948, Dr. A. Levy and I reported¹³ an unusual case of asthma in a one year old infant, traced to exposure to tobacco smoke. While doing routine skin tests by the passive transfer method, a positive tobacco extract test was discovered. We then questioned the mother and learned that she was an incessant cigarette smoker and smoked when nursing, feeding, and diapering the baby. All smoking in the house was stopped and within a few days the baby's asthma, cough, nasal and eye symptoms cleared completely. The baby was well for the next eighteen months, when a dry cough developed. It was found that the mother had started smoking again. She stopped; the baby's cough ceased within a few days and the baby has been well.

Were it not for the positive tobacco test, I am certain the cause of this asthma would not have been discovered.

PRESENT SURVEY

RECENTLY, I reviewed the office records of 200 consecutive patients seen in the private practice of allergy. These patients had asthma, hay fever, perennial allergic rhinitis, eczema, urticaria, gastro-intestinal allergy or migraine.

Using a mixed tobacco leaf extract, assorted domestic and Turkish (Center Laboratory) there were 38 good positive tobacco reactions (19 per cent). Of these 38 positive tobacco reactors, four had definite clinical entities which cleared completely on stopping smoking. Symp-

toms of asthma, cough, migraine, and urticaria, respectively, could be reproduced by smoking.

CASE REPORTS

No. 1. A 23-year old white male was first seen in September 1947, with a history of perennial cough and frequent attacks of asthma. Symptoms began three years previously while the patient was in the Army. There were no nasal symptoms and no previous history of allergy. The patient had been a smoker, averaging about a pack of cigarettes a day for the past seven years. Physical examination revealed mild asthma at this time. Intracutaneous tests showed positive reactions to dust, ragweed, wool, kapok, and tobacco. The patient has been treated with hyposensitization injections against dust and ragweed and had some mild asthma except for the first few months of 1952 when he gave up smoking and became symptom-free. He was not able to refrain from smoking, returned to his pack of cigarettes a day, and asthma has been present ever since.

No. 2. A 17-year old boy, first seen in December 1950, had a hacking cough for many years. Seven years previously the patient had severe swelling of the eyes and lips and generalized urticaria. These symptoms lasted for three days and required many injections of adrenalin. Four years previously the patient had some wheezing and this was diagnosed as asthmatic bronchitis. Physical examination was negative except for some slight asthmatoïd breath sounds. Intracutaneous tests showed positive reactions to dust, ragweed, alternarius and tobacco. The patient did not smoke and the parents had observed that ever since childhood his cough was aggravated when people smoked near him. It was difficult to avoid contact with smoke entirely but by taking strict precautions, symptoms were greatly relieved.

No. 3. A 42-year old male was first seen in January 1947. He had a complaint of buzzing in his right ear for the previous two years. Stuffed nose and frontal headaches were present for six years. He had several attacks of mild urticaria in the past. There was no history of hay fever, asthma, or food sensitivity. Physical examination was negative except for a mildly allergic appearing nasal mucosa. Intracutaneous tests showed positive reactions to feathers, alternarius, tobacco, silk and wool. The patient had discovered he would get a severe headache immediately after smoking and therefore had given up smoking about ten years previously. In April 1947, he was exposed to a great deal of tobacco smoke while visiting some friends. That evening he had an intense aggravation of his buzzing symptoms and a migraine attack occurred accompanied by nausea and vomiting and paresthesia of his hands and feet. The symptoms persisted for the next few days.

No. 4. A 23-year old male, first seen in August 1950, complained of daily urticaria for the previous

five months. There was no past history of any allergy except for poison ivy in childhood. The patient had a great deal of tension mostly due to financial problems. He had a sick father whom he had to support, and he recently married against family objections. Physical examination was negative except for moderate, generalized urticaria. Intracutaneous tests showed positive reactions to dust, feathers, orris, cotton seed, pyrethrum, wool, kapok, and tobacco. The patient had been smoking more than usual when the rash appeared. Three days after his initial visit it was suggested that he stop smoking. His rash cleared and has not recurred.

Unfortunately, desensitization injections with tobacco extracts are of no help and life can be very difficult for the rare person who is allergic to tobacco smoke.

In questioning the 162 patients in this series who gave negative skin tests to tobacco extract none could be found whose symptoms were directly due to smoking. For example, many of the asthma patients in this group were smokers, and asthma was helped by cessation of smoking, but none of these patients cleared completely when they stopped smoking.

VALUE OF TOBACCO TEST

NEITHER tobacco leaf nor tobacco smoke extract duplicate too well the actual smoke as it contacts the nose, mouth, and lungs. Tobacco extract positive skin tests do not correlate with clinical symptoms nearly as well as those with pollens, dusts, and feathers.

Smoking, however, is so widespread, that even if one in ten or one in fifty patients can be relieved of his asthma or other allergic manifestations by detecting a tobacco sensitivity, the tobacco skin test would be worth while.

Other methods of detecting sensitivity to smoking should not be neglected. Perhaps an exaggerated increase in pulse rate or greater drop in skin temperature of the extremities after smoking may be helpful in determining who should not smoke. Possibly electrocardiographic patterns before and after smoking may determine who shall be a non-smoker before cardiac damage occurs. Much more work is needed in this field.

SUMMARY AND CONCLUSIONS

1. Certain people cannot smoke without getting respiratory, cardiovascular and other symptoms. It is felt that these patients are allergic to tobacco smoke.
2. The controversial medical literature is reviewed as to the value of the tobacco skin test.
3. This paper reports two hundred consecutive patients seen in the private practice of allergy. Thirty-eight of these patients (nineteen per cent) gave good positive skin tests to tobacco leaf extract. Of these thirty-eight patients, four had clinical confirmation of the positive tests and allergy symptoms cleared entirely on cessation. These four case histories are presented.
4. Because smoking is so widespread, tobacco extract skin testing should be done, even if only one patient in ten or more clinically confirms the positive test.
5. Other methods are suggested for determining sensitivity to tobacco smoke.

32 Johnson Avenue

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JACOB SCHMUKLER, M.D., Newark: To those interested in the treatment of peripheral vascular diseases, the widespread use of tobacco, especially cigarettes, poses a very acute problem. Our efforts to eliminate the use of tobacco by patients who present themselves for treatment make but a tiny breeze in the vast clouds of smoke. Many a lower extremity has been needlessly sacrificed on this altar of fire. And so, we have to appeal to our colleagues also interested in this problem for some help in this matter: the psychiatrist to analyze the extreme attachment and the allergist to weed out the susceptibles.

Our problem could be easily solved if we "could give it back to the Indians." Smoking is truly an American Indian custom, discovered by Columbus in 1492 when he landed on San Salvador. Brought back to Spain, the habit spread first to Europe, then to Asia, and with the English colonization it returned to America.

At first, tobacco was chewed, snuffed and smoked in pipes. In 1801 the cigar was first made in America and the cigarette was introduced here by the English about 1858. There has been a meteoric rise in its use and now there are about 400 billion cigarettes made and consumed in the United States each year.

Much has been written in regard to the physical and psychologic effects of smoking; companionship, sociability, visual and tactile pleasure and soothing and stimulation of nerves are claimed as its virtues.

THE medical literature concerns itself chiefly with the pathologic effects on the various organic systems of the body, and a voluminous literature dating from about 1850 is now available. Chiefly explored was the effect of smoking on the cardiovascular system but more recently the effects on the upper respiratory system, the lungs and the gastro-intestinal tract have been investigated.

To date sharp differences of opinion still exist but in peripheral vascular disease it is almost universally accepted that smoking tobacco is a very important contributing factor

if not a primary cause, especially in thrombo-angiitis obliterans.

Many attempts have been made to explore the mechanism by which tobacco exerts its harmful effects. It is not possible in a discussion of this nature and limited scope to do more than enumerate the findings of the many competent workers in this field.

Smoking causes a vasoconstriction of the peripheral blood vessels of the extremities in all individuals as demonstrated by plethysmography, capillary microscopy and skin temperature determinations. The result is the same with all types of cigarettes; medicated, denicotinized, etc. Associated with vasoconstriction is a distinct rise in the blood sugar level. Although there are approximately 33 end products of combustion, adequate evidence is available to show that the vascular effects are produced by the nicotine itself in the smoke and is more pronounced with deep inhalation. Habitual smokers do not develop tolerance, and there is considerable variation in the susceptibility to smoking tobacco.

POSSIBLE mechanisms of action are direct action of the nicotine on the adrenals, action on the brain centers, action on nerve endings, allergic response.

One group showed a high degree of sensitivity to tobacco as determined by skin tests in patients with thrombo-angiitis obliterans. Other competent groups demonstrated an equal number of positive reactions in control groups, showing that no specific relationship has been established on an allergic basis.

Be that as it may, certain conclusions can be reached:

Millions of people smoke billions of cigarettes and use other forms of tobacco as well.

As a result of many circumstances, smoking today is commenced at an early age by a great number of boys and girls.

Actuarial figures show that approximately fifty per cent of the population will die of cardiovascular diseases which may be aggravated by tobacco.

Too many people continue to use something they like, though it may be harmful to them. They refuse to stop smoking even with the knowledge that it may mean the loss of life or limb.

We have as yet no adequate substitute to offer these smokers.

IN SPITE of the comparatively few individuals who show harmful effects of smoking when compared with the number who actually use tobacco, it is still very important to pick out the susceptible ones in order to avoid the catastrophes of peripheral vascular diseases such as

gangrene and amputations. How is this to be done? The result of skin testing with tobacco leaf extract is controversial. This may be due to the fact that the irritating substances result only from tobacco combustion and not from the inert leaf.

More work should be done with smoke extract on adolescents or even children, to tell in advance whether the individual will be a reactor; whether the harmful effects will be on the peripheral vascular tree, the heart, lungs or stomach. It would probably be a simple procedure to halt the smoking activities of young people before they become addicted to its use, and so help avert future complications.

Angina Pectoris*

Nitroglycerin remains the preparation of choice in the treatment of an acute attack of angina pectoris. Recent studies show that Peritrate® may be of value in diminishing the frequency of attacks. Xanthines remain of doubtful value even after fifty years of use.

Papaverine appears to produce little subjective or objective improvement in most patients with this disease. Khellin has been used with encouraging results in some groups of patients but unfortunately toxic reactions to this drug are not rare.

In severe angina radioactive iodine has replaced the thiurea derivatives because of the greater ease in which a hypometabolic state can be produced. If myxedema occurs it can be controlled with small amounts of thyroid.

Anticoagulants are used in patients who show impending coronary occlusion. Weight reduction in obese patients is important. Vitamins, cytochromes and irradiation to the spine and adrenal glands are no longer in use.

The surgical treatment of angina pectoris is recommended only when medical management has failed. The operation of choice in poor

risk patients is paravertebral alcohol injections. Sympathectomy is of special value in patients who have both angina and hypertension. Good results occur in about 57 per cent of cases.

Posterior rhizotomy, which relieves pain in 95 per cent, is a major operation but it allows severance of the nerve fibers at one operation. Stellate-ganglion block and pericoronary neurectomy are rarely used today.

The blood supply to the heart can be improved by grafting vascular tissues to the heart and by provoking inflammation on the surface of the heart. However, the operative mortality remains high. Arterialization of the coronary sinus has been done on a large number of patients, but long-term follow up studies on these cases are still too few to be evaluated. The operation is technically difficult and the mortality high.

Intracardiac collateral circulation may be improved by ligation of the great coronary vein with a complete absence of effort pain in 49 per cent.

Angina pectoris may occur with variable periods of remission and caution should be exercised in interpreting results of treatment because of this important fact.

*Uricchio, J. F. and Calanda, D. G.: Treatment of Angina Pectoris. New Eng. J. Med., Oct. 22, 1953.

Trustees' Meeting

October 25, 1953

(Minutes approved January 10, 1954)

A regular meeting of the Board of Trustees was held on Sunday, October 25, 1953, at the Executive Offices, Trenton. The following is a summary of the principal actions taken by the Board at this meeting:

A motion was adopted authorizing the continued issuance of public relations membership certificates to new members until the present supply of certificates is exhausted.

The president's action in granting permission to the State Department of Institutions and Agencies to list the state society as co-sponsor of its Conference on Juvenile Delinquency was confirmed.

Approval was granted to the request of the Division of Chronic Illness Control of the State Department of Health that the state society cooperate in offering postgraduate courses dealing with the early detection and control of chronic disease.

Confirmation was made of the president's action in granting permission to the State Department of Health to list the state society as a co-sponsor of the Governor's Conferences on Diabetes, Alcoholism, and Epilepsy.

The Board authorized that a letter be sent to Congressman Charles Wolverton offering the assistance of the state society in the study of long-term illness which his congressional committee is currently making.

Approval was given to the annual meeting schedule of 1954, to the speaker arrangements, and budget allotments.

A motion was adopted authorizing a representative from the Advisory Committee on the Conservation of Vision and Hearing to serve as a consultant to the State Commission for the Blind. Dr. William C. Braum, Camden, was so designated.

A recommendation of the Subcommittee on Medical Practice that the Advisory Committee on Physical Medicine and the Advisory Committee on Rehabilitation merge to form an Advisory Committee on Rehabilitation and Physical Medicine was approved.

Approval was given to recommendations urging support of legislation to facilitate the obtaining of consent for post-mortem examinations, to restrict the sale of ready-made prescription glasses, to bring school optometrists under the supervision of school physicians, and to amend the Society's charter of 1864 so as to remove the annual income limitation.

The Board also approved a recommendation of the Subcommittee on Legislation that the Society record its continued support of the Jenkins-Keogh Bill now before the Congress, the purpose of which is to eliminate arbitrary discrimination against self-employed and professional people with respect to retirement benefits.

A statewide educational program, at county level by county societies and auxiliaries, directed to both the public and the members of the medical profession, to establish and satisfactorily operate effective county-approved systems of medical coverage and emergency service, was approved by the Board as the primary public relations project for 1953-54.

The nomination of Mrs. Mary G. Roebing as chairman of the Citizens' Committee for the Medical-Dental School was approved.

A motion was adopted whereby the president, past-president, and president-elect will regularly represent the state society on its liaison committees with the New Jersey Bar Association, New Jersey Hospital Association, and the New Jersey Pharmaceutical Association. The Executive Officer holds membership on these committees *ex-officio*.

After protracted and detailed study, approval was given to the proposed new contract of the Medical-Surgical Plan. The Board stipulated, however, that the section dealing with consultations should make it clear that immediate recognition should be made of the desire to establish clarifying criteria for consultants, and that reinclusion of consultation as an eligible service be accomplished as soon as feasible.

Current Quarantine Regulations

The New Jersey Department of Health wishes to call the attention of physicians to the following regulations regarding incubation, isolation and quarantine periods for patients with certain communicable diseases.

REGULATION 29. MAXIMUM PERIOD OF INCUBATION OF CERTAIN COMMUNICABLE DISEASES

For purpose of this Code, the maximum period of incubation of the following communicable diseases is hereby declared as follows:

Diphtheria	7 days
Measles (rubeola)	14 days
Meningococcal meningitis	7 days
Pertussis (whooping cough)	14 days
Poliomyelitis	14 days
Salmonellosis (other than typhoid fever)	14 days
Smallpox	21 days
Streptococcal sore throat, including scarlet fever	7 days

REGULATION 30. MINIMUM PERIOD OF ISOLATION AND QUARANTINE

The minimum period of isolation and quarantine of persons who are isolated or quarantined because of illness or infection with the following communicable diseases shall be as follows:

DISEASE	ISOLATION FOR PATIENT	QUARANTINE FOR CONTACTS
Chickenpox (varicella)	Until seven days after the appearance of the rash.	No restrictions.
Diphtheria	Until two successive cultures from the nose and two from the throat taken not less than 24 hours apart beginning at least seven days after cessation of drug therapy, if used, are found to be free from virulent diphtheria bacilli by a laboratory approved by the State Department of Health for such examination.	Twenty-four hours after satisfactory isolation of patient has been established contacts may be released when one culture from the nose and another from the throat are found to be free from virulent diphtheria bacilli by a laboratory approved by the State Department of Health for such examination. If satisfactory isolation of patient has not been established, members of household shall be quarantined until the period of isolation of last case in the household has been terminated and the release culture standards described above have been met.
German measles (rubella)	No restrictions.	No restrictions.
Measles (rubeola)	As soon as fever and catarrhal symptoms of the eyes, nose and throat are detected and until seven days after appearance of rash.	Household contacts under 18 years, who have not had measles, shall be quarantined from the seventh to the fourteenth day after exposure.
Meningococcal meningitis	Until seven days after onset, or for the duration of fever, if longer.	Household contacts under 18 years shall be quarantined for seven days.
Mumps	Until seven days after onset and all swelling of the salivary glands has subsided.	No restrictions.

DISEASE	ISOLATION FOR PATIENT	QUARANTINE FOR CONTACTS
Pertussis (whooping cough)	Until 21 days after onset of the paroxysmal cough.	No restrictions.
Polioomyelitis (infantile paralysis)	For seven days after onset or for the duration of fever, if longer.	Intimate home contacts under the age of 18 years shall be quarantined for 14 days.
Scarlet fever (including streptococcal sore throat)	In uncomplicated cases, until clinical recovery, or not less than seven days. Patients with complications resulting in purulent discharges shall be isolated as long as discharges persist.	Home contacts under the age of 18 years shall be quarantined for seven days.
Smallpox (variola)	Until 14 days after onset of illness and until all lesions are healed.	Home contacts and other persons exposed to the risk of contracting smallpox by proximity to a case or suspected case of the disease shall be vaccinated and quarantined until vaccination is successful or until evidence of protection is established to the satisfaction of the local health officer. Persons released from quarantine shall be kept under observation for not less than 21 days from the date of last exposure. Contacts who refuse to be vaccinated shall be quarantined for at least 21 days from the date of last exposure and until discharged by the local health officer.

Announcements • • •

Surgical Meeting

The New Jersey Chapter of the American College of Surgeons and the Section on Surgery of The Medical Society of New Jersey will hold their annual joint luncheon at 12:30 p.m., Tuesday, May 18 in the West Room of Haddon Hall. Members of the College will be contacted by mail. Non-members are requested to make reservations with Dr. Paul Mecray, Jr., 405 Cooper Street, Camden.

Alumni Meeting

The State University College of Medicine at New York City (formerly Long Island College of Medicine) will hold its annual Alumni Day on Saturday, May 1. Further information may be obtained from Ruth Goodwin, Executive Secretary, 350 Henry Street, Brooklyn 1, N. Y.

Venereal Disease Pamphlet

The Bureau of Venereal Disease Control, Department of Health, has available for distribution to physicians, without charge, a new publication of the Public Health Service entitled *Management of Venereal Disease*.

Copies of this brochure may be obtained by writing to the venereal disease control bureau at 1 West State Street, Trenton, N. J.

Officers Elected

The New Jersey Chapter of the American College of Surgeons elected the following officers at their annual meeting on February 6: *president*, Dr. Paul M. Mecray; *vice-president*, Dr. Philip Kunderman; *secretary*, Dr. Benjamin Daversa; and *treasurer*, Dr. Charles Hoffman.

At the same meeting the annual surgical prize was awarded to the authors of the paper, "Appendices Epiploicae: Clinical and Pathological Considerations," by Drs. Stanley S. Fie-

ber and Jerome Forman of the Veterans Administration Hospital in East Orange.

The New Jersey Chapter announces an annual prize of \$100.00 to be given yearly for the best surgical paper published by a resident of a New Jersey hospital and a similar prize for the best unpublished paper by an intern of one of the hospitals in our state.

Pediatrics Course

A six-week course in pediatrics for the general practitioner will be given at St. Michael's Hospital, Newark, starting Wednesday, March 31. The program will consist of morning ward rounds, special clinics and demonstrations starting at 11:00 a.m. Topics to be covered include pediatric allergy, intestinal disorders in children, diseases of the chest, metabolism, emergencies and central nervous system infections.

The fee for the course will be \$25.00. Further information may be obtained by writing to Dr. Harrold A. Murray, care of St. Michael's Hospital, Newark, New Jersey.

Psychiatric Residencies

The Veterans Administration Hospital, Lyons, announces that it is accepting applications for one to three year residencies in psychiatry, approved by the American Board of Psychiatry and Neurology.

The training program consists of lectures, conferences and seminars under the direction of the Department of Psychiatry, New York Medical College, as well as a series of extensive guest lectures.

Further information may be obtained by writing directly to the hospital itself in Lyons, New Jersey.

Physical Medicine Meeting

The eastern sectional meeting of the American Congress of Physical Medicine will be held in Newark, on Saturday, April 10. At 10:00 a.m. there will be a tour of the Department of Physical Medicine and Rehabilitation of the Veterans Administration Hospital, East Orange. The afternoon session will start at 2:00 p.m. at the Academy of Medicine in Newark.

Further information may be obtained from Herman L. Rudolph, M.D., 500 North Fifth Street, Reading, Pennsylvania.

Geriatrics Lectures

The Kessler Institute for Rehabilitation announces that Martin Gumpert, M.D., New York City, will deliver a series of six lectures on problems of aging starting Thursday, April 15 at 7:30 p.m.

The lectures are open to the lay public as well as professional workers. There is an admission charge of \$5.00 for the entire series.

Pediatric Cancer Course

The Memorial Center for Cancer and Allied Diseases announces that its Pediatric Service will hold a three-day course for pediatricians, general practitioners and health officers concerning childhood cancer, April 28-30.

Benign and malignant tumors, Hodgkin's disease, leukemia and reticuloendotheliosis in childhood will be considered. The registration fee is \$35.

Further details may be obtained from the Director, Pediatric Service, Memorial Center, 444 East 68th Street, New York City.

County Society Reports • • •

Burlington

A regular meeting of the *Burlington County Medical Society* was called to order by Dr. Freeman W. Metzger, president, on December 10, 1953, at the Riverton Country Club.

The scientific session consisted of a paper, "Recent Advances in the Treatment of Hypertension," presented by Dr. Garfield G. Duncan, Director of the Division of Medicine, Pennsylvania Hospital and the Benjamin Franklin Clinic.

During a short business meeting that followed, Dr. Luis E. Viteri announced that the Burlington County Heart Association has set aside a sum of money for the medical and surgical care of needy heart patients in our county.

On January 14, the *Burlington County Medical Society* sponsored a dinner meeting for the Burlington County Bar Association at the Riverton Country Club with Dr. Freeman W. Metzger presiding.

Guest speaker was Mr. David Bronsky, District Supervisor, Narcotics Division, Bureau of Internal Revenue, whose topic was "The Physician and the Narcotic Law." Various contacts that a general practitioner might possibly have with the drug addict were outlined.

During the business meeting, the following officers were elected for 1954-1955: *President*, Dr. L. E. Viteri; *President-Elect*, Dr. M. A. Robbins; *Vice-President*, Dr. R. T. Buckley; *Secretary*, Dr. R. W. Betts; *Treasurer*, Dr. W. P. Mulford; *Reporter*, Dr. J. A. Steitz.

WILLIAM F. BETSCH, M.D.
Reporter

Camden

Case report night, an annual event, featured the January 8 meeting of the *Camden County Medical Society* with President Edwin R. Ristine in the chair.

The scientific program consisted of three unusual case presentations. Dr. David S. Masland (by invitation) described bilateral rupture of the inferior epigastric arteries. Dr. Luke W. Jordan presented a case of Ewing's sarcoma and Dr. James Eynon a case of fulminating ulcerative colitis.

Drs. Charles E. Meidt, Francis G. Meidt, James R. Herron and John R. Rushton were elected to full membership. Dr. Edward F. Mazur of Camden was accepted for membership by transfer from the Burlington County Medical Society.

Dr. William J. Snape outlined the aims, advantages, and advisability of a public health forum, or Health Fair to be sponsored by our county society in the naval armory on April 23, 24 and 25. The community will be invited to view exhibits and

encouraged to discuss medical topics with their physician hosts. The need for active participation of all county members was stressed.

President Edwin R. Ristine opened the regular monthly meeting of the *Camden County Medical Society* on February 2, at the Cooper Hospital in Camden.

Dr. William T. Snagg, chairman of the Program Committee, introduced a panel composed of Drs. William J. Snape, Edwin R. Ristine, and Reuben L. Sharp, who conducted the discussion on duodenal and gastric ulcer. The physiologic aspects (W.J.S.), the medical therapy (R.L.S.) and the surgical care (E.R.R.) of this problem were briefly, but pointedly, reviewed.

Dr. Vincent T. McDermott presented a memoir which he had prepared on the passing of Dr. Robert E. Imhoff.

Dr. Louis Coriell reminded the society of the forthcoming Public Health Forum to be held in April.

Drs. Raymond A. Baker and Arthur Glass of Camden, Rade R. Musulin of Haddonfield, Anthony J. Oropallo of Barrington and Robert L. Rehmann of Haddon Heights were elected to membership.

FREDERICK W. DURHAM, M.D.
Reporter

Middlesex

The regular monthly meeting of the *Middlesex County Medical Society* was held at the Roosevelt Hospital, Metuchen, January 20, with Dr. Malcolm Dunham, presiding.

Dr. Mathilda R. Vaschak, Medical Director of E. R. Squibb & Co., New Brunswick, was elected to regular membership on transfer from the Kings County Medical Society. Dr. Gloria Stone Aitken, at present in Japan, was elected from associate to regular membership.

The date of the May meeting was changed from the nineteenth to the twelfth, to avoid conflict with the state society's annual meeting.

The society voted to establish a minimal office fee of \$4.00 in this county, and interested insurance companies were so notified. Display cards for office use bearing this information will be printed and distributed to the members.

IVAN B. SMITH, M.D.
Reporter

Monmouth

The regular monthly meeting of the *Monmouth County Medical Society* was held at the Borden Memorial Auditorium of the Monmouth Memorial

Hospital at Long Branch on January 27, under the gavel of the president, Dr. George McDonnell.

Dr. Schuyler G. Kohl, Assistant Professor of Obstetrics and Gynecology at the School of Medicine, State University of New York, spoke on prenatal mortality.

The regular business meeting followed. Dr. Samuel Stevens of Deal was elected to active membership. Drs. Richard W. Goslin of Rumson and Edwin Morris of Red Bank were accepted as associates.

MORTON F. TRIPPE, M.D.
Reporter

Morris

The *Morris County Medical Society* held its regular meeting at the Dutton Hotel in Dover on January 21.

The society was host to the Tri-County-Dental Society, and the evening was an informal one featuring a speaker, one "Doc Sims," who presented an amusing program.

ALBERT ABRAHAM, M.D.
Reporter

Union

The regular meeting of the *Union County Medical Society* was held at the White Laboratories, Kenilworth, on January 13. The following were elected to membership: Dr. Hugh McCulloch, Jr. and Dr. Joseph J. Phillips, Plainfield; Dr. Joseph Raymond, Scotch Plains; Dr. Anthony L. Spirito, Elizabeth, and Dr. Vincent R. Tanzi, Linden. Received into membership by transfer were Dr. Leo Burnstein, Elizabeth, and Dr. Bernard Rosenberg, Linden, both from Essex County, and Dr. Kenneth E. Jones, Linden, from Lehigh County, Pa.

The scientific portion of the meeting was devoted to cancer. A short description of the three cancer clinics in Union County was given by their respective directors, Dr. William O. Wuester, Green Memorial Tumor Clinic, Elizabeth General Hospital, Elizabeth; Dr. George L. Erdman, Overlook Hospital, Summit; and Dr. Joseph M. Gannon, Muhlenberg Hospital, Plainfield.

The paper of the evening was given by Dr. James A. Corscaden, professor emeritus of Obstetrics and Gynecology at Columbia University, who spoke on carcinoma of the cervix.

M. L. GRISWOLD, JR., M.D.
Reporter

Woman's Auxiliary Reports • • •

Camden

The Woman's Auxiliary to the *Camden County Medical Society* held its regular meeting on February 2, at the Haddon Fortnightly in Haddonfield.

Mrs. Kenneth L. Athey, president, presided at the business meeting, after which the 1954-55 officers were elected.

Following the meeting, Mrs. A. M. K. Maldeis introduced Mrs. Alfred M. Chapman, of Washington's Crossing, Pennsylvania, who gave an inspiring talk entitled, "Building a Better World."

The choral group of the auxiliary, under the direction of Mrs. Francesca D'Imperio, then entertained with several musical selection.

MRS. GEORGE W. HAGER, JR.
Publicity Chairman

Essex

On January 22, with the president, Mrs. Stuart Z. Hawkes in the chair, the high spot of the program was an interesting account of observations

on alcoholism. The speaker was Dr. Harold W. Lovell, a nationally known psychiatrist. He pointed out that medical science has not yet fully determined the value of new anti-alcohol "wonder drugs" and at present the only positive cure for alcoholism is complete abstinence.

Mrs. Thomas Delaney, executive secretary of the Essex Service for the Care of the Chronically Ill, displayed a "Question and Answer board" used in educational programs of her organization. The Essex County Service for the Chronically Ill is a non-profit, voluntary, cooperative county-wide agency which is studying the problems of long term illness and disability under the auspices of Essex County Medical Society.

The Nurse Recruitment Committee has been engaged in publicizing the great need for nurses. The shortage of nurses is more acute in New Jersey than in any of the nine states in close proximity to it. Pamphlets containing current and pertinent facts will be sent to all high schools, vocational schools and junior high schools in Essex County.

At this meeting 34 new members were welcomed into the auxiliary for 1954.

MRS. HARRY E. DIGIACOMO
Chairman, Press and Publicity

The Nursing Mother. By Frank H. Richardson, M.D., formerly consulting editor, Archives of Pediatrics. Pp. 204. New York, Prentice-Hall, Inc., 1953. (\$2.95)

This book should be on the "must" list of every doctor whose practice includes obstetrics and infant feeding. The arguments presented for and against nursing are factual and scientific. Dr. Richardson's organization of his book provides a new perspective on a familiar subject. In addition, the recent researches which he cites are highly significant. He avoids the overenthusiasm which has characterized previous writers and maintains a rational "middle road" approach to this topic.

While this book offers valuable reading for the medical profession, it was written primarily for the layman. It gives prospective parents facts they will want to know. It dispels the ignorance and misinformation which most young parents have. The book explains in detail the technic of successful nursing. The exposition is clear, complete and practical, and is amply illustrated by sketches and photographs.

With the current interest in breast feeding, this book may well become the household guide to breast feeding, comparable to Dr. Spock's *Common Sense Book of Baby and Child Care*.

C. PRENTISS WARD, M.D.

The Psychiatrist: His Training and Development. J. C. Whitehorn, M.D., editor. A Report of the 1952 Conference on Psychiatric Education. Pp. 214. Washington, D. C., American Psychiatric Association, 1953. (\$2.50)

As might be expected, psychiatrists are an introspective group. They not only keep in operation an extensive reproductive apparatus (the instruments for training more psychiatrists), but they subject that apparatus to constant self-scrutiny. This work is the protocol of one of these exercises in introspection. It is the report of a conference organized by the American Psychiatric Association and the Association of American Medical Colleges and financed largely through grants from the U. S. Department of Health, Education and Welfare.

An analysis of residency training is the core of the report. Residencies are analyzed (in the statistical rather than in the psychoanalytic sense of that verb) in all possible planes—numbers, location, duration, supervision, eligibility, etc. Some attention is given to certain subspecialties such as child psychiatry, administration, forensic psychiatry, industrial psychiatry, civil defense, *et al.*

The anatomy of the conference itself is displayed in one appendix. In another is the roster of the

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

participants in the conference by name and organizational affiliation. There is also a short list of special institutions which offer training for therapy, and a rich collection of charts, graphs and tables dealing with the graduate training of the psychiatrist.

The volume is, of course, of limited appeal. It will be valuable to medical educators in all branches of the profession if for no other reason than its analysis of a conference technic and its exhibit of the ways of study training. It will be interesting to psychiatrists and of considerable tangential value to social workers, psychiatric nurses and clinical psychologists. To anyone who is contemplating entry into the specialty, the book will be a gold-mine.

ABRAHAM LEFF, M.D.

Clinical Management of Behavior Disorders in Children. By Harry Bakwin, M.D., Professor of Clinical Pediatrics, New York University, and Ruth Morris Bakwin, M.D., Associate Professor of Clinical Pediatrics, New York University. Pp. 495. Philadelphia, W. B. Saunders Company, 1953. (\$10.00)

Designed as a practical guide for the understanding and management of behavior disorders in children, this book is intended not only for physicians but also for professional workers in child psychology.

There is an excellent description of normal emotional growth and maturation and general principles of psychologic care. The sections on fear, sex education, self-demand feeding, training and discipline are especially good. Many excellent suggestions for lessening the emotional trauma in the physically ill and handicapped child are included. The need of a hospitalized child for warm human contact, especially with the parents, is stressed. Chapters on mental function, development abnormalities, habit and training, organic disturbances with a large psychic element, anti-social behavior, cerebral damage, schizophrenia, and accident proneness all contain useful information and suggestions for the management of these conditions.

The consideration of etiologic factors, however, is too brief. Parental attitudes and problems of sibling rivalry are considered, but a fuller exposition of the emotional interaction between parent and child would have been desirable. The problem of diagnosis is dismissed by stating that preoccupation with a diagnosis can lead to neglect of other factors. This reviewer feels that an adequate diagnosis—based on a psychodynamic understanding of all the etiologic factors—is just as important in psychologic disorders as in strictly medical ones. Accordingly, some diagnostic scheme might have

been included. In this connection it is of interest that the diagnostic term psychoneurosis does not appear anywhere in the book. The volume states that it is difficult to distinguish between "normal" and "abnormal" behavior. Although some criteria for making this distinction have been included, a fuller elaboration would have been helpful.

The chapter on treatment covers such topics as improving parental attitudes, correction of physical defects, training, drugs, rewards, clubs, camps, foster homes, and institutional care, as well as some general comments on psychotherapeutic principles. There is a brief description of "abnormal emotional states," under which are listed anxiety states, phobias, obsessions and compulsions, impulsions, and hypochondriasis. The treatment recommended consists of general measures. This reviewer feels that these conditions result from specific emotional conflicts in the child and from psychopathology in the child-parent relationship, and that intensive psychotherapy dealing with these conflicts in child and parent is necessary.

In summary, this volume will help the busy physician understand the psychologic background of behavior disorders in children. It will enable him to deal with these situations on a general level and should help him recognize when intensive psychotherapy by a qualified psychiatrist is indicated. Non-medical professional workers in the field of child psychology will learn a great deal about the medical and organic background of these disorders. To the physician dealing with psychiatric treatment of emotionally disturbed children this volume has limited value.

BERNARD GERMAN, M.D.

Respiratory Diseases and Allergy. By Josef S. Smul, M.D. Pp. 80. New York, Medical Library Co., 1953. (\$2.75)

That a book on respiratory diseases should be written by a gastro-enterologist will be a surprise to most physicians. In this short book Dr. Smul, a Fellow of the National Gastro-Enterology Association and associate gastro-enterologist at the Beth-David Hospital, proposes certain radical, unorthodox, and unapproved theses. In his first chapter, the author lists twenty-two upper respiratory conditions and then proceeds to obliterate them all, from "neurosis of the respiratory tract" to bronchiectasis, by encompassing them in the single term "respirallergy." He then considers each one individually and explains it as a manifestation of allergy of the upper respiratory tree. While it is freely admitted that many upper respiratory conditions may have an allergic background, one is not justified in concluding that *all* such disorders are purely allergic in origin. Moreover, Dr. Smul presents no documentary evidence either by way of individual case reports or statistical data to substantiate his theory. If any contribution is made at all, it is merely to point out that upper respiratory conditions which fail to respond to ordinary management at least should be given the opportunity of an allergic study.

Section two is entitled Infectious Diseases of the Respiratory System. Here is presented rather straightforward and routine descriptions of the common infections such as acute tonsillitis, diphtheria, pertussis, etc. Chest physicians will be startled by the brief allotment of space given to some major chest conditions. Infarction of the lung is discussed in less than two pages. Pulmonary tuberculosis fares a little better: it is allotted three pages. In Section three, entitled Neoplastic Diseases of the Respiratory System tumors are amazingly covered in a few lines less than two pages.

R. D. GOODMAN, M.D.

Thoracic Surgery and Related Pathology. By Gustaf E. Lindskog, M.D., William H. Carmalt Professor of Surgery, and Averill A. Liebow, M.D., Professor of Pathology, Yale University School of Medicine. Pp. 644. New York, Appleton-Century-Crofts, Inc., 1953. (\$15.00)

Lindskog and Liebow have approached their subject in a comprehensive manner. The entire realm of thoracic surgery is covered concisely but with enough detail for clarity. Also included are present-day concepts of cardiovascular pathology and its treatment. All but the rarest conditions of the chest are reported in this volume.

The book is divided into chapters, each chapter follows a similar pattern; a short historical review precedes a discussion of diagnosis, indications, contraindications, complications and sequelae as well as the expected long term result. The chapter on respiratory function studies and their clinical application and evaluation is noteworthy, as are the pages on preoperative and postoperative care. An excellent bibliography is included.

DAVID WIENER, M.D.

Surgical Forum. Proceedings of the Forum Sessions, Thirty-eighth Clinical Congress of the American College of Surgeons, New York City, September, 1952. Pp. 716. Philadelphia, W. B. Saunders Co., 1953. (\$10.00)

As in the past, this reviewer has been most favorably impressed by the material presented in the Surgical Forum. The papers included in this volume deal with the recent advances in preoperative and postoperative care and surgical technic as well as the results of research in the field of basic medical sciences. The individual papers are usually short, so the busy practitioner can quickly get the gist of the subject without being burdened by lengthy reviews of the literature on the subject. There is no doubt that the reader will get more useful information from this volume than from any other single specialty journal he may read. Since the book contains papers on such a wide range of subjects, every surgeon, regardless of specialty, will be well rewarded by browsing through these pages.

HENRY REICH, M.D.

TUBERCULOSIS *Abstracts*

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DIABETES AND TUBERCULOSIS

By Elmer S. Gais, M.D., *New York State Journal of Medicine*, August 15, 1953.

Tuberculosis occurs frequently as a complication of pre-existing diabetes mellitus. The fact that this combination of diseases is lethal unless recognized early and treated vigorously is of utmost importance. The incidence of tuberculosis is higher in the diabetic than in the general population. Recent evidence is presented by the Philadelphia Survey in which 8.4 per cent of the 3,106 diabetics studied were tuberculous, whereas 4.3 per cent of a group of 70,767 industrial workers were found to harbor tuberculosis.

From this survey other important conclusions were drawn: (1) tuberculosis was *active* in 2.6 per cent of the diabetics and was three times as prevalent in those under 40 years of age as in those 40 or over; (2) the prevalence of active tuberculosis increased markedly with severity of the diabetes and was greater in underweight persons than in overweight; (3) in the younger age group the prevalence of active tuberculosis was much greater in those having had diabetes 10 years or more; (4) tuberculosis was much more likely to be active in diabetics than in nondiabetics.

No conclusion was reached as to the effect of degree of control of diabetes on the incidence of tuberculosis. The juvenile diabetic at present survives into the decades when tuberculosis becomes more prevalent; thus the opportunity for exposure and increased incidence of tuberculosis becomes a function of time itself. If underweight is evidence of undernutrition and inadequate control, then the increased incidence in this group may reflect the hazard of poor diabetic control.

A statistical case for the beneficial effect of im-

proved diabetic care can be made by a comparison of the declining mortality of the diabetic from tuberculosis in the various eras of diabetic therapy, which seems to be related to the longer lasting insulin effect with better control. However, the effect of improved treatment of tuberculosis must be evaluated, particularly since the overall mortality from tuberculosis is declining more rapidly than that from diabetes.

From a presently incomplete study of several hundreds of tuberculous diabetic patients treated in Montefiore Hospital, (N.Y.), under uniform supervision over the past 15 years, it appears that more thorough control of the diabetes yields a definitely higher survival rate, *almost equaling the survival rate of the nondiabetic tuberculous patient in the same institution receiving the same therapy for his tuberculosis*. This conclusion is tentative and may have to be modified somewhat in the light of stricter analysis.

What is the reason for the increased susceptibility of the diabetic to infections, in this instance, tuberculosis? Many theories have been advanced, among the latest of which is the effect of adrenal steroids on the immune reaction in tuberculosis. Overproduction of such contrainsulin steroid or pituitary factors, particularly in the older age group of diabetics, may well be a determining factor in the causation of diabetes and of altered immunity. This might also explain the high incidence of true insulin resistant diabetes in tuberculosis. But in the younger age group of diabetics, deficiency of insulin itself seems to be the prime cause of diabetes. Yet this age group has a high rate of active tuberculosis. Further studies may resolve this dilemma.

The course of tuberculosis in the diabetic is

usually stated to be more active, more progressive and leading to more frequent generalized spread. Many features of the pathology of the disease warrant this conclusion. Fewer, less dense pleural adhesions, rendering pneumothorax easier, less fibrosis, more caseation and a low incidence of amyloid disease, attest to the more rapid progress of the disease. There seems to be no difference in native immunity to tuberculosis in diabetics. Healed primary lesions are usual. But something occurs after development of diabetes which lowers the normal resistance to tuberculosis infection, and the disease may progress rapidly.

There is no essential difference in the localization of the tuberculous infection in the diabetic and the nondiabetic. The onset is no more insidious, but it is very often missed. The old rule that "in every diabetic who is not doing well without apparent cause, suspect tuberculosis" still holds. The minimum of a semi-yearly roentgenogram of the chest is a small price to pay for early diagnosis! It is well to remember that tuberculosis may become active very frequently in the older age groups as in the younger.

At Montefiore Hospital there is no limitation placed on the treatment of the tuberculous patient because he has diabetes. Under proper management there is no reason to fear ketosis. Premature vascular disease in a diabetic may preclude extreme surgical procedures. But, by and large, these patients can be treated for tuberculosis almost as if the diabetes did not exist. Chemotherapy is used according to the newer concepts. The possible increase in insulin requirement resulting from isoniazid therapy is offset by the decrease from the improved febrile state, so that diabetic balance is maintained. The important principle is to treat the disease vigorously. All diabetic subjects who develop tuberculosis should be hospitalized immediately in an institution equipped to treat both diseases.

The diabetes should be treated to maintain adequate nutrition in a chronic, debilitating, febrile disease. The diabetes is rendered more severe as a rule, but a satisfactory degree of stabilization

occurs even with the fluctuating course of the infection. The diet should be attractive and varied. Over- or underweight should be avoided. Most patients on enforced bed rest tend to become overweight. The vascular, neuropathic, and other complications of diabetes when encountered are treated in the usual manner.

Insulin is necessary in at least 95 per cent of the patients. The longer-lasting insulins are quite satisfactory but frequently must be supplemented. With the fluctuations in the infectious process minimal glycosuria and near normoglycemia are often difficult to accomplish, but with constant vigilance can nearly be attained. Fractional urines are used as the base for regulation, and even a slight ketosis is treated vigorously. We have had no deaths from diabetic coma.

A few practical points may be mentioned. Re-adjust the insulin dosage slowly. Fluctuations in the infection, changes in appetite, and the tendency for long-institutionalized patients to relax their regimes are factors in control. Above all, avoid hypoglycemia with its attendant danger of unconsciousness and aspiration of infected material with bronchogenic spread. A slight glycosuria will avoid this hazard. Whenever a persistent aglycosuria occurs, it is wise to reduce the insulin dosage promptly but gradually.

With vigorous therapy, a hopeless outlook is no longer necessary. Preliminary uncorrected analysis of the first 100 of the cases in Montefiore Hospital from 1936 to 1941 shows a five-year mortality rate of 24.2 per cent against a rate of 22.9 per cent of nondiabetic tuberculous patients. This is also evidenced by the increasing number of discharges of arrested cases, who are an excellent group of well-controlled diabetics.

The watchwords are early detection and prompt, vigorous treatment of both diseases.

(This abstract was prepared from one of the articles entitled "Current Concepts in Diabetes Mellitus" published under the auspices of the Committee on Professional Education of the Clinical Society of the New York Diabetes Association.)

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			Duodenal	Jejunal	Stomal	Gastric	Good	Fair	Poor	No Report			Complete	Moderate	None	No Report
Grimson, Lyons, Reeves	100	100	93	7			80	11	4		5		47		19	29
Friedman	15	15	14			1	5		4	6 ¹			2			13
Bechgaard, Nielsen, Bang, Gruelund, Tobrassen	26	26	21			5	16	4	6				8	6	12	
McHardy, Browne, Edwards, Marek, Ward	162		162				136	12	11		3	1	14	9	7	129
Segal, Friedman, Watson	34	34	34 ¹				14	13			7	2	5		8	14
Brown, Collins	117	99	117				97	7	8		5	8	55	9	8	40
Asher	77		65		7	5	52	9	16			16		9	21	47
Rodriguez de la Vega, Reyes Diaz	5	4	5				4		1					3	2	
Winkelstein	116	116	102	8		6	102		14				53		18	45
Hall, Hornisher, Weeks	18	18	18				11		1	6 ¹			18			
Maier, Meili	38	38	24			14 ¹	27	7	4 ¹				10	2	5	21
Meyer, Jarman	25	18	25				21		4							25
Poth, Fromm	37	37	37				33	3	1				33	3	1	
Plummer, Burke, Williams	41	41	41				36		5				38		3	
McDonough, O'Neil	104	100	104				63	10	31			11	4		11	89
Broders	60	60	58		1	1	35	19	6				10	1	49 ¹	
Legerton, Texter, Ruffin	11		11				11									11
Holoubek, Holoubek, Langford	76	69	76				35	27	10		4	10	26		10	36
Ogborn	42		39	2		1	42 ¹									42
Shaiken	48	48	48				33	10	3		2		33	10	3	
Johnston	145	145	145				143		2			2	143		2	
Rossett, Knox, Stephenson	146		141			5	146					4 ¹⁰	53			93
TOTALS	1443	968	1380	17	8	38	1142	132	131	12	26	54	552	52	179	634
PERCENTAGES		67.8	95.6	1.2	0.6	2.6	81.3	9.4	9.3			3.7	70.5	6.6	22.9	

1. Not included in tabulations.

2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."

3. Four had no symptoms when Banthine therapy was begun.

4. Of which seven were penetrative lesions and five partially obstructive.

5. No symptoms were present in four.

6. Two with symptoms only; no demonstrable ulcer.

7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.

8. Roentgen findings after treatment period of two weeks; forty-seven had duodenal deformity.

9. All returned to work within a week.

10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past three years, more than 250 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 783 patients on whom reports were available.

In all but 9.3 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

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Changes in the mood pattern are just a few of the many distressing symptoms of declining ovarian function which are so often disguised because they do not always coincide with cessation of menstruation, and at times will occur long before, and even years after. Other good examples are insomnia, headache, easy fatigability, arthralgia — and understandably so, when one considers that the loss of ovarian hormone "withdraws one of the most important metabolic regulators of the organism."²

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1. Malleson, J.: *Lancet* 2:158 (July 25) 1953. 2. Goldzieher, M. A., and Goldzieher, J. W.: *Endocrine Treatment in General Practice*, New York, Springer Publishing Company, Inc. 1953, p. 23.

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REFERENCES

1. Freed, S. C. and Mizel, M.: Annals of Int. Med. June 1952
2. Dripps, R. D.: J.A.M.A. 139:148-150 (Jan. 15) 1949
3. Council on Pharmacy and Chemistry (Drug products used for obesity) (Prac. Phar. Ed) 8:436 (Sept.) 19

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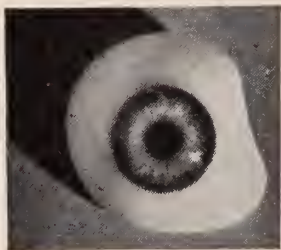
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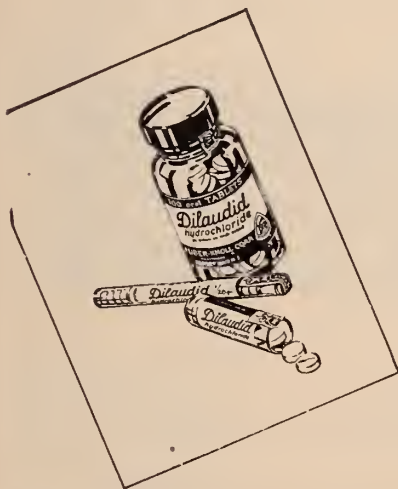
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1. Blotner, H., and Marble, A.: New England J. Med. 245:567 (Oct. 11) 1951.

2. Steine, L.: GP 8:45 (July) 1953.

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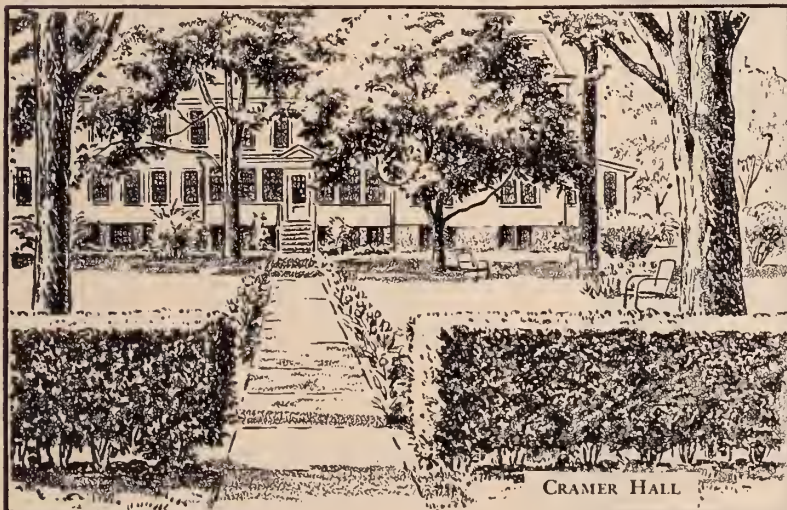
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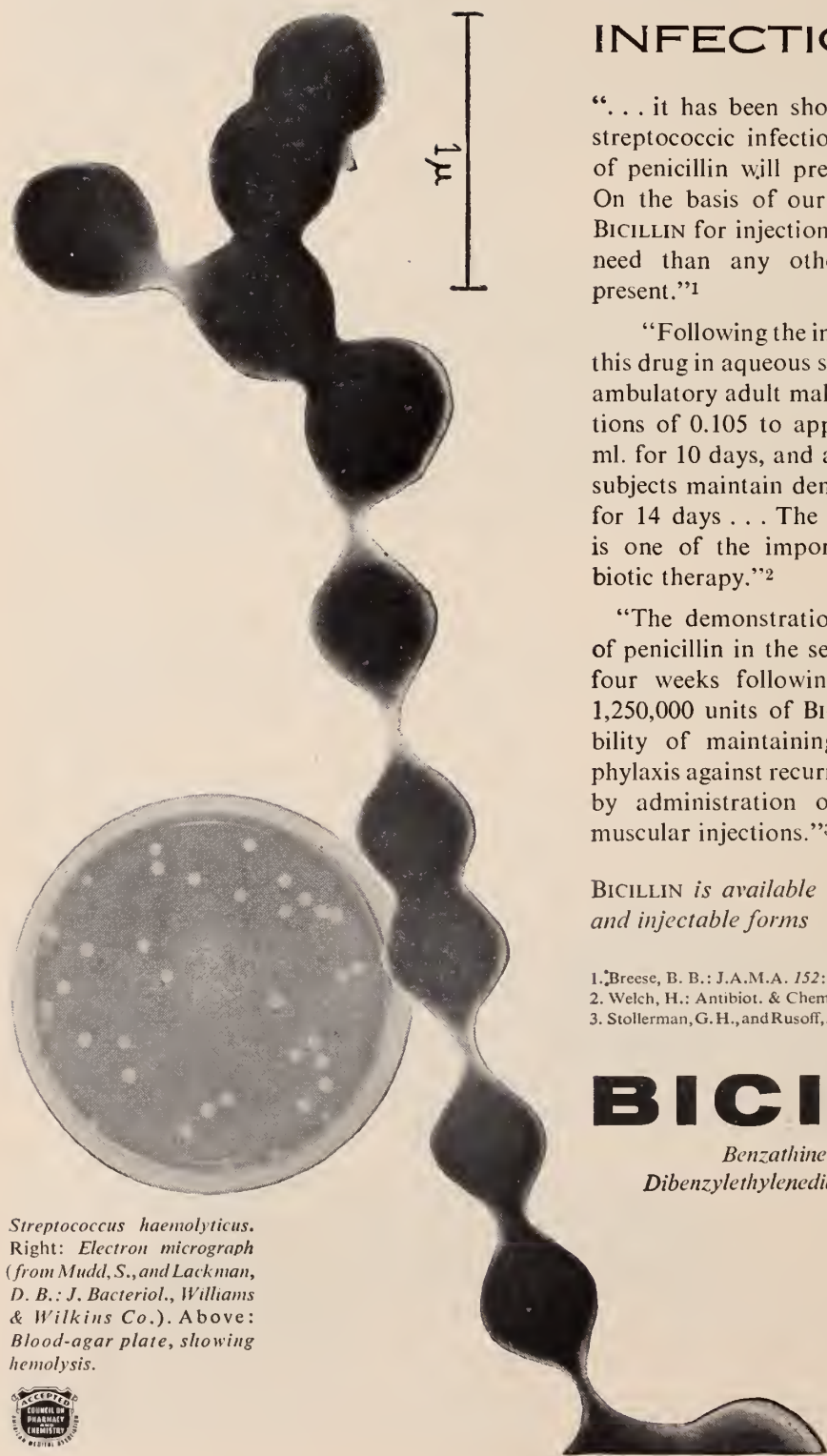
1. Breese, B. B.: J.A.M.A. 152:10 (May 2) 1953

2. Welch, H.: Antibiot. & Chemo. 3:347 (April) 1953

3. Stollerman, G. H., and Rusoff, J. H.: J.A.M.A. 150:1571 (Dec. 20) 1952

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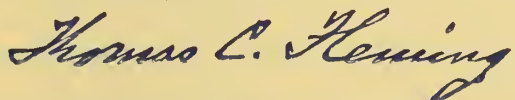
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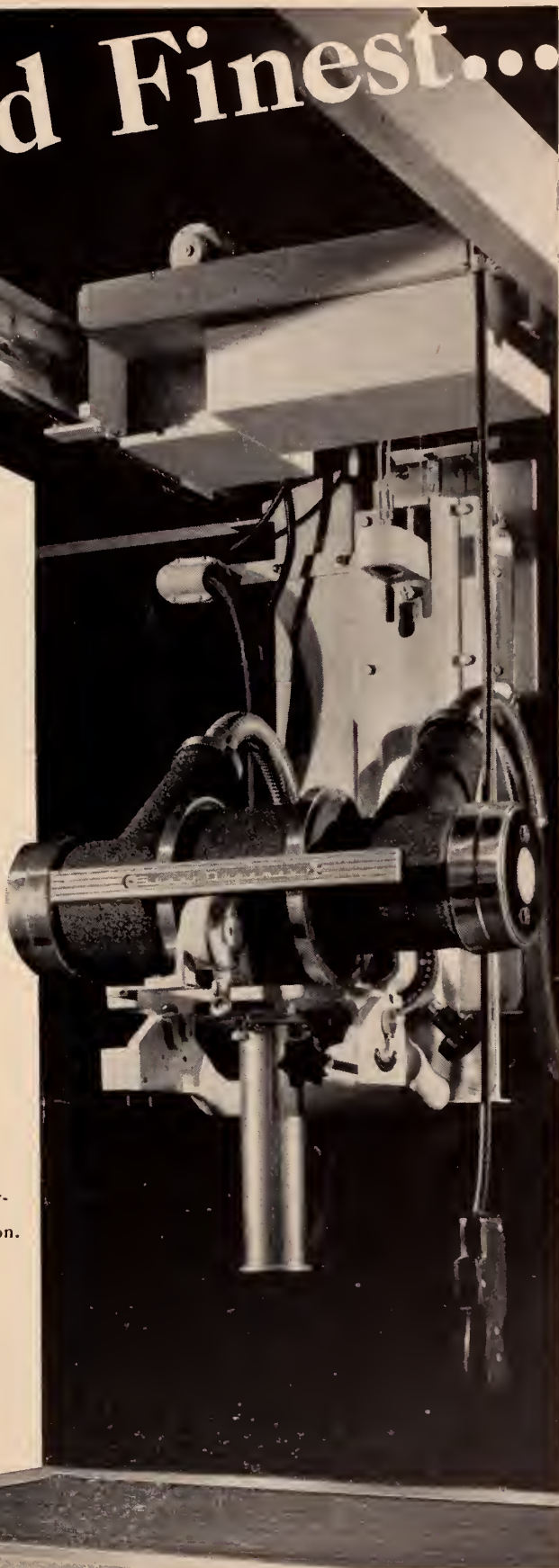
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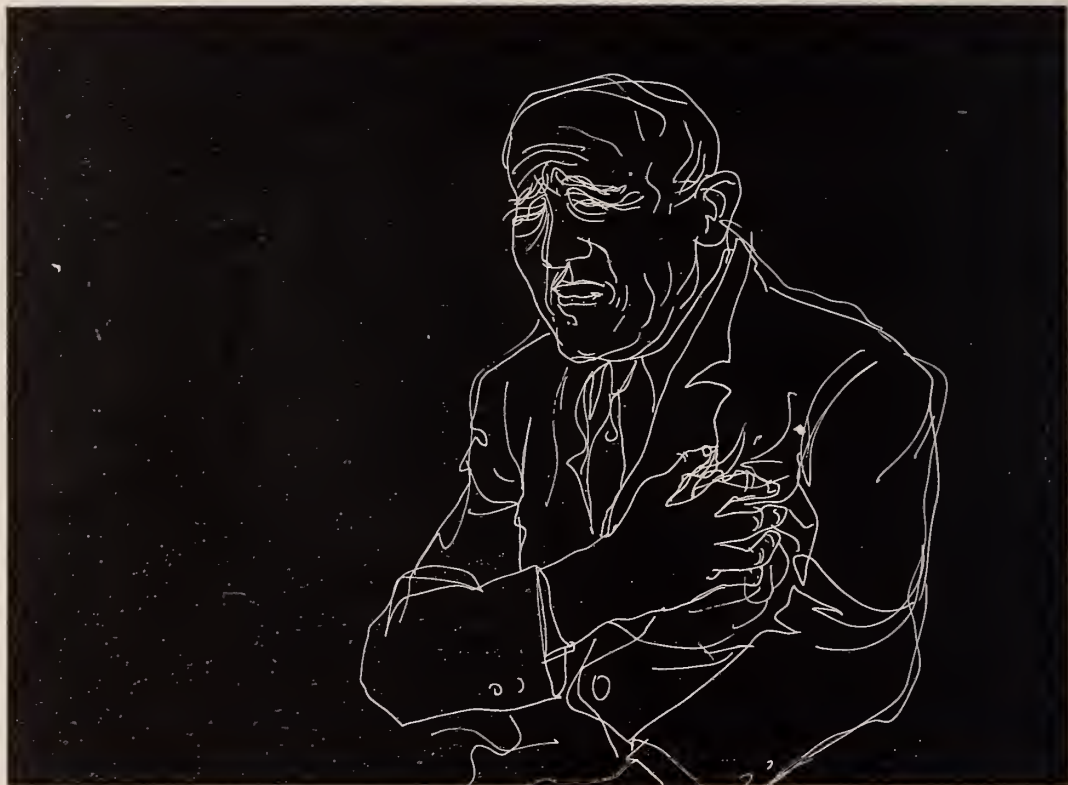
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1. Russek, H. I.; Urbach, K. F.; Doerner, A. A., and Zohman, B. L.: J.A.M.A. 153:207 (Sept. 19) 1953.
2. Humphreys, P., et al.: Angiology 3:1 (Feb.) 1952.
3. Plotz, M.: New York State J. Med. 52:2012 (Aug. 15) 1952.

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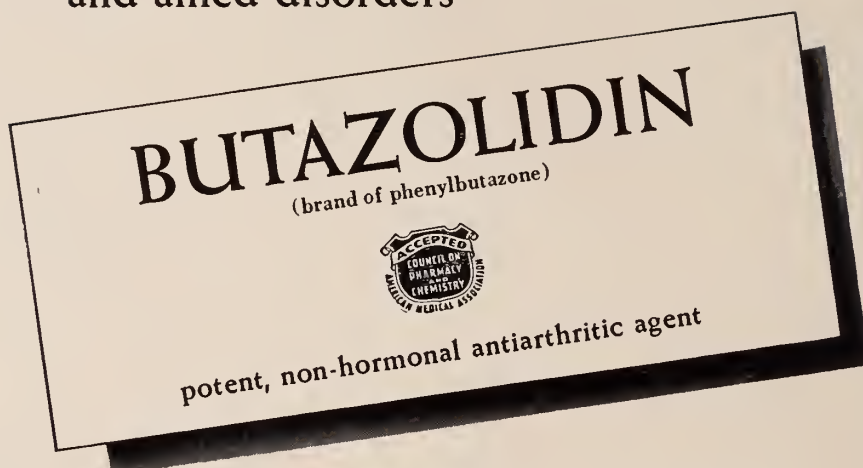
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¹Zink, O. C.. Routine Clinical Experiences Using Urokon 70% in Intravenous Urography (Private Report dated May 12, 1952).

²Nesbit, R. M. and Nesbitt, T. E.: Experiences with High Concentration Urokon for Pyelography. Univ. of Mich. Med. Bull. 18:225 (1952).

³Barry, C. N. and Rose, D. K. Urokon Sodium 70% in Excretory Urography, J. Urol. (to be published).

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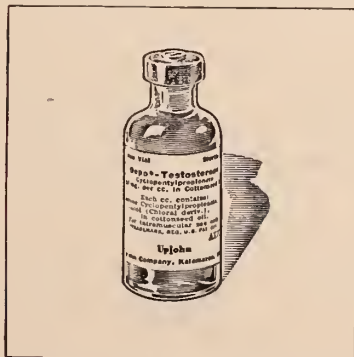
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1. Greenblatt, R. B., and Kupperman, H. S.: *M. Clin. North America* 30:576 (May) 1946. 2. McGavack, T. H., in Goldzieher, M. A., and Goldzieher, J. W.: *Endocrine Treatment in General Practice*, New York, Springer Publishing Company, Inc., 1953, p. 225.

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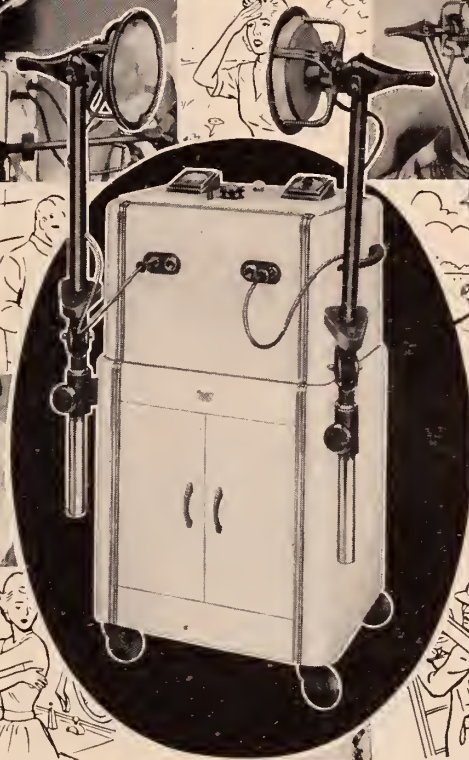
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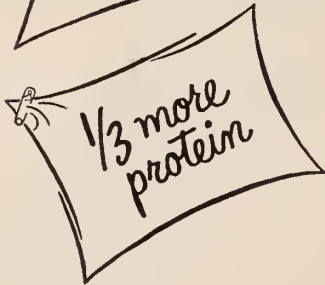
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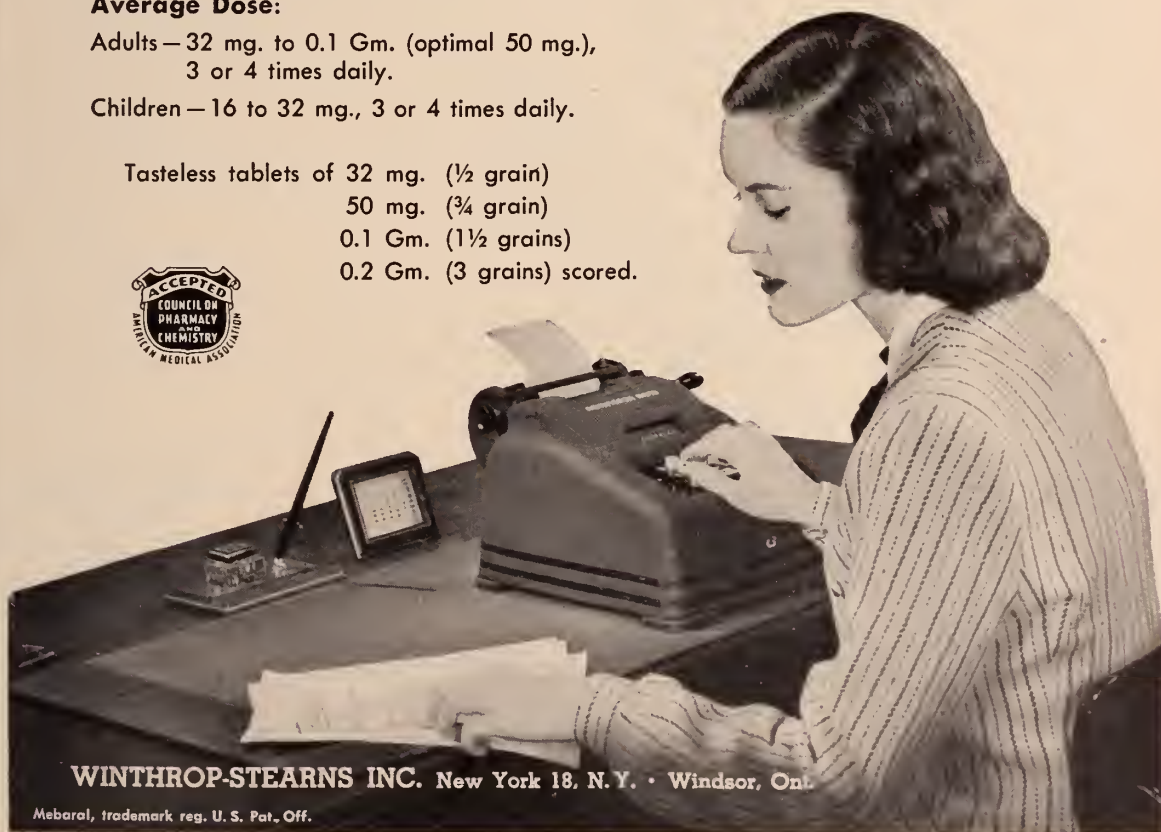
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1. Cowart, E. C., Jr.: Mississippi Doctor 29:278 (April) 1952.
2. Sayer, R. J., et al.: Am. J. M. Sc. 221:256 (March) 1951.
3. Knight, V.: New York State J. Med. 50:2173 (Sept. 15) 1950.
4. Trafton, H. M., and Lind, H. E.: J. Urol. 69:315 (Feb.) 1953.



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*English, A. R., et al.: *Antibiotics Annual (1953-1954)*,
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*Stead, E. A., Jr., in Cecil, R. L., and Loeb, R. F.: Textbook of Medicine, ed. 8, Philadelphia, W. B. Saunders Co., 1951, p. 1065.

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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Consultation Service for Convulsive Disorders

A new statewide consultation service for patients with convulsive disorders has been established in New Jersey through the cooperation of state agencies and a voluntary organization interested in these problems.

Known as the New Jersey Consultation Service for Convulsive Disorders, the new program is the result of close cooperation by the State Department of Health, the State Department of Institutions and Agencies, and the New Jersey Society for Crippled Children and Adults.

This new service will take Dr. Melvin D. Yahr, a neurologist with special training and background in seizure control, into all parts of the state to regularly scheduled consultation clinics, where he will see patients referred by physicians from the surrounding areas. The patient's social and vocational problems also will be studied by a team of rehabilitation personnel working with Dr. Yahr.

Reports and recommendations will be sent back to the referring physician. This is a consultation service only. Treatment of the patient

will remain in the hands of the community physician.

These clinics will be held one day each week, rotating among four districts within the state. To facilitate follow-up on clinic medical recommendations, a "contact physician" has been selected in each of the four areas. Each of these physicians has had a special orientation course at New York Neurological Institute under the direction of Dr. Yahr. In the intervals between consultation clinics in each district, the contact physicians will serve as liaison between the Service consultant and the local physician. Referrals for this consultation service should be addressed to 42 Walnut St., Newark. Follow-up on non-medical procedures will be provided by community welfare and public health services, with assistance from the Service rehabilitation team.

In close support of this Consultation Service—but organically separate from it—will be seizure clinics at the four hospitals attended by the contact physicians. Each of these hospital clinics will be equipped with an electroenceph-

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alograph machine and a trained technician. Each clinic is located in an area where facilities were previously non-existent or inadequate.

In this program the Department of Institutions and Agencies is providing the medical personnel and part of the non-medical personnel for the Consultation Service through the New Jersey Neuro-Psychiatric Institute at Skillman; the Department of Health is supplying the electroencephalograph machines and technicians through its Division of Chronic Illness Control; the New Jersey Society for Crippled Children and Adults is contributing part of the non-medical personnel for the Consultation Service, coordination for the program, and other services.

The Medical Society of New Jersey has a real stake in this program. This Consultation Service is the latest development derived from a proposal for a statewide epilepsy program made by the Medical Society to the New Jersey Society for Crippled Children and Adults in 1950. This plan originated in the Medical Society's Advisory Committee on Mental Hygiene, which has served as the Medical Advisory Committee to the Epilepsy Project since its establishment by the Society for Crippled Children and Adults in 1951. Through this committee the Medical Society has participated in the planning and implementation of this new Consultation Service which offers valuable help in a difficult area. The physicians of the State should welcome and make use of it.

It's Your A. M. A.

To criticize is easy, especially when the critic does not have all the facts. Great organizations, like great men, provoke the most ardent admiration and the most bitter slander. The American Medical Association, representing as it does one hundred and forty thousand practicing physicians, has always been subject to complaint and criticism, even, unfortunately, from some of its own members. The reason is undoubtedly that the A.M.A.'s most controversial programs and policies are widely publicized while little notice is given to its many helpful and beneficial practices.

For those who really want to know what the A.M.A. is, its history, organization, policies and operations, an attractively prepared and profusely illustrated booklet is available. In the first section, after a short paragraph describing the beginnings of the A.M.A., its purpose is clearly set forth: "To promote the science and art of medicine and the betterment of public health." This section describes the democratic organization of the A.M.A., explains that it is composed of nineteen hundred and eighty-seven county and district medical societies all of which elect representatives to fifty-three state and territorial medical asso-

ciations. In turn, each of these state groups elects representatives to the national House of Delegates on a proportional basis. It further explains that the House of Delegates, which serves as the national legislature, meets twice yearly to set policy and determine the A.M.A.'s program. The House of Delegates represents not only the state medical societies but each of the twenty sections of the A.M.A.'s scientific assembly. Thus, every branch of medicine is represented as well as the Army, Navy, Air Force, Veterans Administration and Public Health Service, each of which has its own delegate.

The executive branch of the A.M.A. consists of the Board of Trustees, the Administrators, the Councils, Bureaus, Departments and Committees. The workings of each of these are clearly explained in this booklet.

The A.M.A.'s part in protecting and improving medical education at the medical school, internship and residency levels is described in the second section. Physician placement, journal publication, an extensive library and council reports on drugs, cosmetics, foods and medical devices are all part of the A.M.A.'s program to help the individual physician.

The A.M.A. also grants financial aid for research projects, maintains a file on quacks and nostrums and cooperates with other organizations in assuring that this country has the finest hospitals. Schools for laboratory technicians, occupational therapists, physical therapists, x-ray technicians and medical record librarians also come under the surveillance of the A.M.A. which inspects and approves them.

The A.M.A. publishes health pamphlets for use in doctors' waiting rooms as well as a lay magazine entitled *Today's Health* which keeps the public informed about sound health habits and preventive medicine.

Information is available on medico-legal problems, either to the practicing physician or his attorney, on a loan basis. The A.M.A. represents physicians in Congress and its policy on any given legislative question is based on that of its House of Delegates.

A complete file on all physicians is maintained by the A.M.A. and the material made public through the American Medical Directory.

The A.M.A. also stands ready to help every state and county society. It provides medical and health films, exhibits for public or professional use, pamphlets, posters, radio transcriptions and TV films. It helps local societies operate a placement service, establish night call systems, organize health councils, plan a school health program, establish mediation (grievance) committees and performs other important functions for organized medicine.

The A.M.A. aids the public by providing lay publications, helping to prepare radio and television programs, maintaining close liaison with newspapers and magazines and exposing quackery. It examines and passes on foods, drugs and similar products.

In summary, the A.M.A. performs a multitude of helpful services which all serve to assist the busy physician in his practice, aid his county and state medical societies and provide the public with the best medical care.

Support of this worthwhile organization, both financial and moral, will strengthen it in accomplishing its purposes.

Vernasthenia

Every year at this time the general population develops a well known syndrome. Lassitude, inability to concentrate and a desire to "get away from it all" are the chief symptoms. When more severe, the patient may become irritable, especially with his family or his boss, and manifest general indifference to his fellow man. The name in the title has been coined to describe what is commonly called "spring fever."

Fortunately every member of The Medical Society of New Jersey has an easy remedy for himself. All he has to do is to spend three or four days at Atlantic City from May 16 through May 19, at the 188th annual meeting of our society. There he will find an oppor-

tunity to relax from the rigors of a busy practice, brush up on any phase of medicine in which he is interested by attending one of several scientific sessions, or partake in the deliberations of the medical society itself. Comfortable accommodations, good food, or the boardwalk and beach may entice him away from these activities, or he may wander leisurely through a small but select collection of interesting scientific and technical exhibits.

The annual meetings of our society are open to every member and all are invited. So, if you wish to enjoy a relaxing yet educational four days you are urged to spend at least some time at this year's annual meeting. Wives and children are invited, as always.

BENJAMIN COPLEMAN, M.D.

Perth Amboy

Contusion Pneumonia

Pneumonia following chest injury is a definite clinical entity, which produces characteristic signs and symptoms and may be demonstrated roentgenographically. Seven cases are presented.

CONTUSION pneumonia is the term applied to a pneumonia which follows non-penetrating injuries to the thorax. The scarcity of papers on this subject warrants a short review and the report of seven cases.

CASE REPORTS

No. 1. An 8-year old white male slipped and hit the right side of his chest on the edge of a swimming pool on October 26, 1952. He had been perfectly well previously. That night he had pain in his chest and a temperature of 103 degrees Fahrenheit. For two days he had a cough and severe right-sided chest pain. His physician found impaired percussion and evidence of consolidation at the right base. There was splinting of the chest and upper abdominal muscles. On October 28, 1952, a chest x-ray showed (Fig. 1A) a large area of consolidation in the subapical portion of the right lower lobe. A special examination of the ribs failed to show any fracture.

His chest was then strapped and 400,000 units of penicillin administered on two successive days. Within 48 hours his temperature was normal and he felt improved. A second chest roentgenogram on November 5, 1952 (Fig. 1B) showed complete resolution of the pneumonic lesion. Re-examination of the ribs again showed no fractures.

No. 2. (Previously reported¹). A 5½-year old Negro girl was struck by an automobile and sustained a chest injury on October 2, 1935. She was brought to the hospital immediately. On admission (11 a.m.), her temperature was normal. She complained of pain in her right chest. Physical examination showed multiple contusions and lacerations over both lower extremities as well as about the head. None were noted over the chest. She was

kept under observation and during the succeeding hours she became drowsy and markedly irritable when aroused. At 4 p.m., her temperature was 101 degrees Fahrenheit and by 5 p.m. it was 101.4 degrees. There was no cough. At 6 p.m. she was acutely ill. Her respirations were rapid. There were impaired percussion and decreased breath sounds at the right base posteriorly. The white cell count was 9,800 with 78% polymorphonuclear leukocytes. A roentgenogram of the chest 8 hours after the injury showed an area of pneumonia at the base of the right lung posteriorly, but no fractured ribs. She became afebrile late the next day and began to show marked clinical improvement on the third hospital day. On that day, a repeat chest x-ray showed complete resolution of the right lower lobe pneumonia. She was discharged on October 11, 1935.

No. 3. (Previously reported¹). An 11-year old Negro boy was struck on the left lower chest by a stick four days prior to admission on January 31, 1938. He complained of pain on breathing, slight cough and had marked tenderness over the left lower ribs anteriorly. His temperature was normal and no signs of pulmonary changes could be found on physical examination. X-ray examination failed to show a fracture of the ribs, but a faint area of increased density was noted in the lower portion of the left lung. He was discharged from the hospital the same day.

No. 4. A 28-year old Negro male, a cook, was admitted to an Army General Hospital with the following history:

Very early in the morning of March 10, 1944, he slipped on a short ladder and fell to the floor, landing flat on his back. He felt instant pain in his left shoulder. He reported to his station dispensary about one and one half to two hours after the accident. By this time, he felt feverish and complained

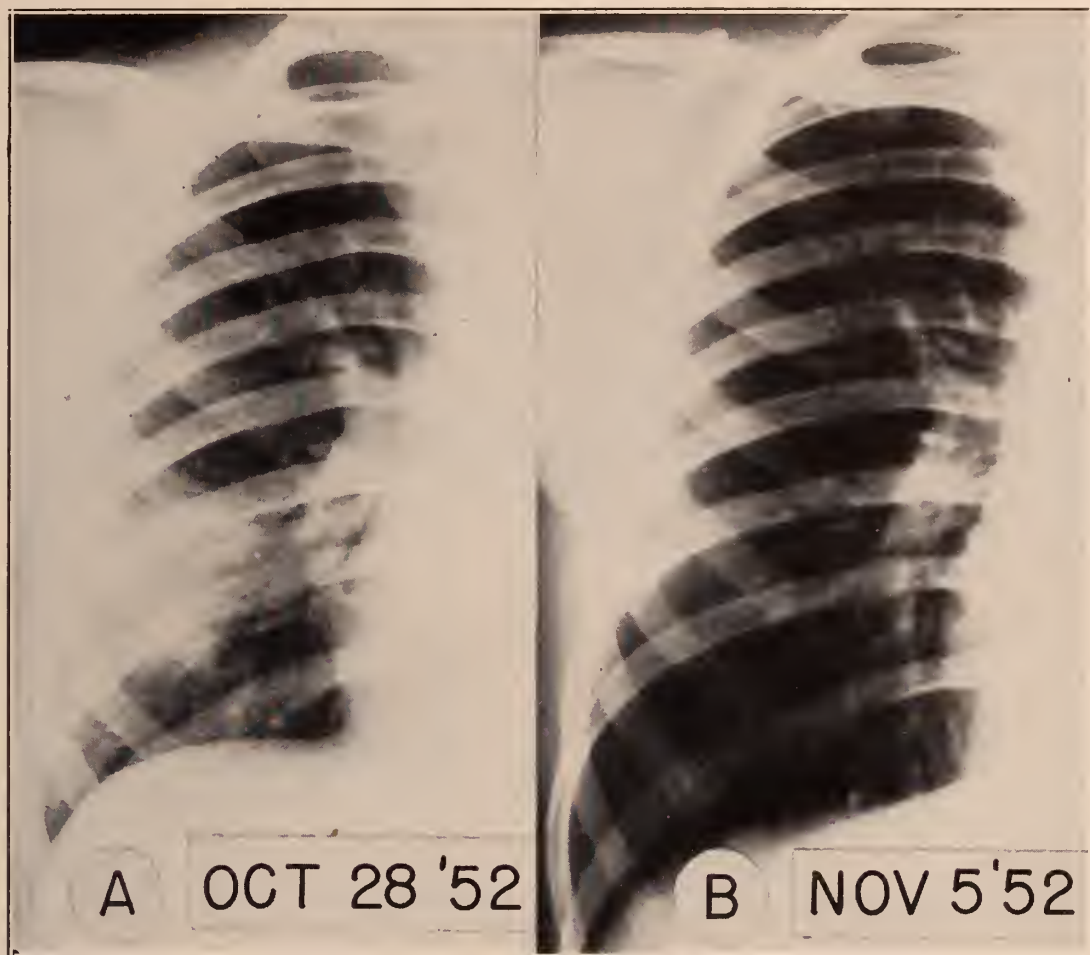


Fig. 1. Case. 1. A.—Two days after injury. The pneumonic lesion shown was demonstrated to be in the subapical portion of the right lower lobe. A special examination of the ribs failed to show a fracture. B—Eleven days after the injury, and nine days after the first examination, showing complete resolution.

of a tightness in both sides of his chest. He began to cough occasionally. On careful and repeated questioning, he stated that he had felt perfectly well up to the time of his accident. He had a temperature of 101 degrees orally. Roentgenograms of his chest, made about an hour after he reported at the dispensary, showed an extensive bilateral pulmonary infiltration, somewhat more marked on the right. There was also a fracture of the spine of the left scapula (Fig. 2A). He was hospitalized and given sulfonamides and the usual supportive treatment for pneumonia. His left arm and shoulder were immobilized with sand bags. His cough gradually subsided, as did his fever and feeling of weakness. On March 16, 1944, another chest roentgenogram showed the lungs to be clear (Fig. 2B).

knocked down and rendered unconscious. A contusion was present on the anterior upper third of the right chest. There was splinting of this side. Breath sounds were diminished.

A chest x-ray made two hours after the injury showed a large area of pneumonia in the middle third of the right lung (Fig. 3A). There were no fractured ribs. White cell count was normal. On September 9, 1947, he had crepitation over the right side of the chest and over the right humerus. Subcutaneous emphysema was demonstrated. No fractures were found. A chest roentgenogram showed much of the pneumonia to have resolved, but two sharply outlined cavities were now present. A small hydropneumothorax was also present (Fig. 3B). A sputum culture on September 15, 1947, showed *Micrococcus catarrhalis* and Friedlander's bacillus. The hydropneumothorax gradually absorbed, and the pulmonary cavities became smaller and had practically disappeared by October 11, 1947. His tem-

No. 5. A. R., a 62-year old male, was struck on the right anterior chest wall by a flying wedge of wood from a nearby saw on September 4, 1947. He was

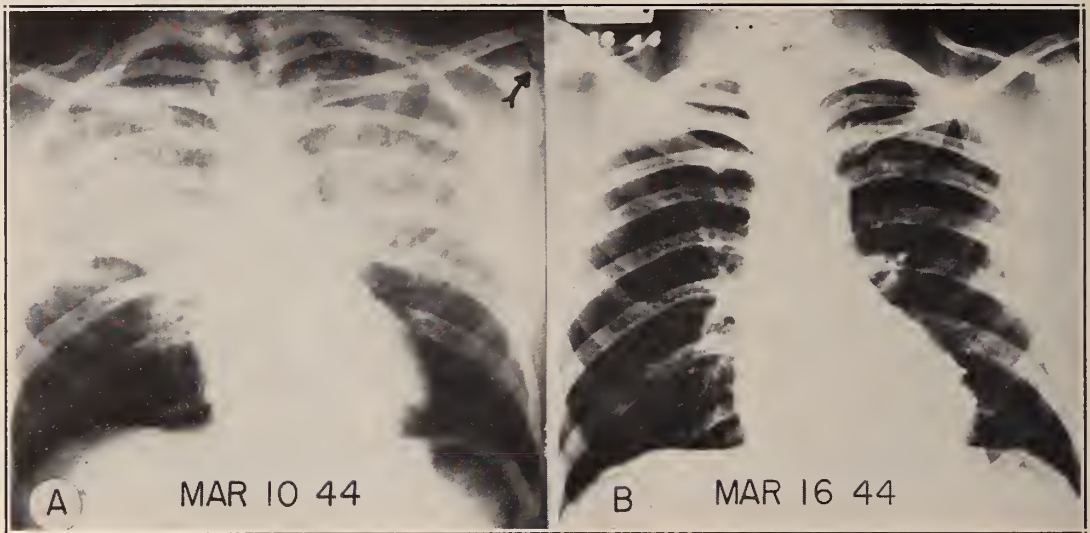


Fig. 2. Case 4. A—About two and one half to three hours after the patient fell flat on his back. Note the fracture of the spine of the left scapula (arrow.) B.—Six days after the injury. The pneumonic lesions are completely resolved. There were no other fractures.

perature, 100 degrees on admission, returned to normal on the fifth hospital day.

No. 6. D. W., a 15-year old boy, was struck on the right side of his chest by a skate while sliding on the ice on January 31, 1948. Immediately following the injury, he complained of pain in the right chest, and expectorated a small quantity of blood. No abnormality could be found on physical examination.

A roentgenogram of his chest two hours after the injury showed a small patch of pneumonia at the base of the right upper lobe anteriorly. A special examination of his ribs showed no fractures. Re-examination of his chest showed almost complete clearing of the right upper lobe pneumonia on February 2, 1948, and complete resolution by February 14, 1948.

His temperature was at no time elevated above normal.

Case 7. R. L., a 35-year old male, was struck by an auto while he was walking on a sidewalk at 7:40 p.m. on October 2, 1952. He had contusions and abrasions of the right side of his chest and complained of pain in this region. Roentgenograms of his ribs at 8:30 p.m. showed no evidence of fracture, but there was an area of increased density in the lower third of the right lung which was thought due to contusion of the lung. The next morning re-examination of his chest showed a small amount of pleural exudate in this region. There was a suggestion of a small amount of air in the axillary soft tissues. His blood count on October 4, 1952: 4,550,000 red blood corpuscles and 10,000 white blood cells per cu. mm. with a normal differential. His temperature was 100 degrees on admission and gradually returned to normal by October 9, 1952.

COMMENT

ANIMAL experiments² have shown that non-penetrating injuries to the chest wall produce bronchial spasm and hyper-secretion, resulting in pulmonary atelectasis. This can be prevented by atropine administration or vagal section, suggesting that the atelectasis is due to vagal reflex. Robertson⁷ showed that local pulmonary irritation or injury may be an important factor in producing pneumonia. Pneumonia following injuries was shown to be no different from lobar pneumonia pathologically⁵ or clinically.⁸ Post-traumatic pneumonia resembles primary pneumonia more closely than the post-operative type.⁸ The data suggests that local interference with respiratory movements has a determining effect on the site of the pneumonia. The pneumonic process most often approximates the site of trauma, but may occur anywhere in the chest.⁴

Studies on blast injuries^{9,10} showed that sudden compression of the chest wall injured the underlying lung. Blows delivered to the anterior and lateral chest walls produce more extensive injuries than those to the thick-muscled posterior wall.⁶ Phillips,⁶ in 73 cases, did not have a single case of pulmonary changes following blows confined to the posterior aspect of the

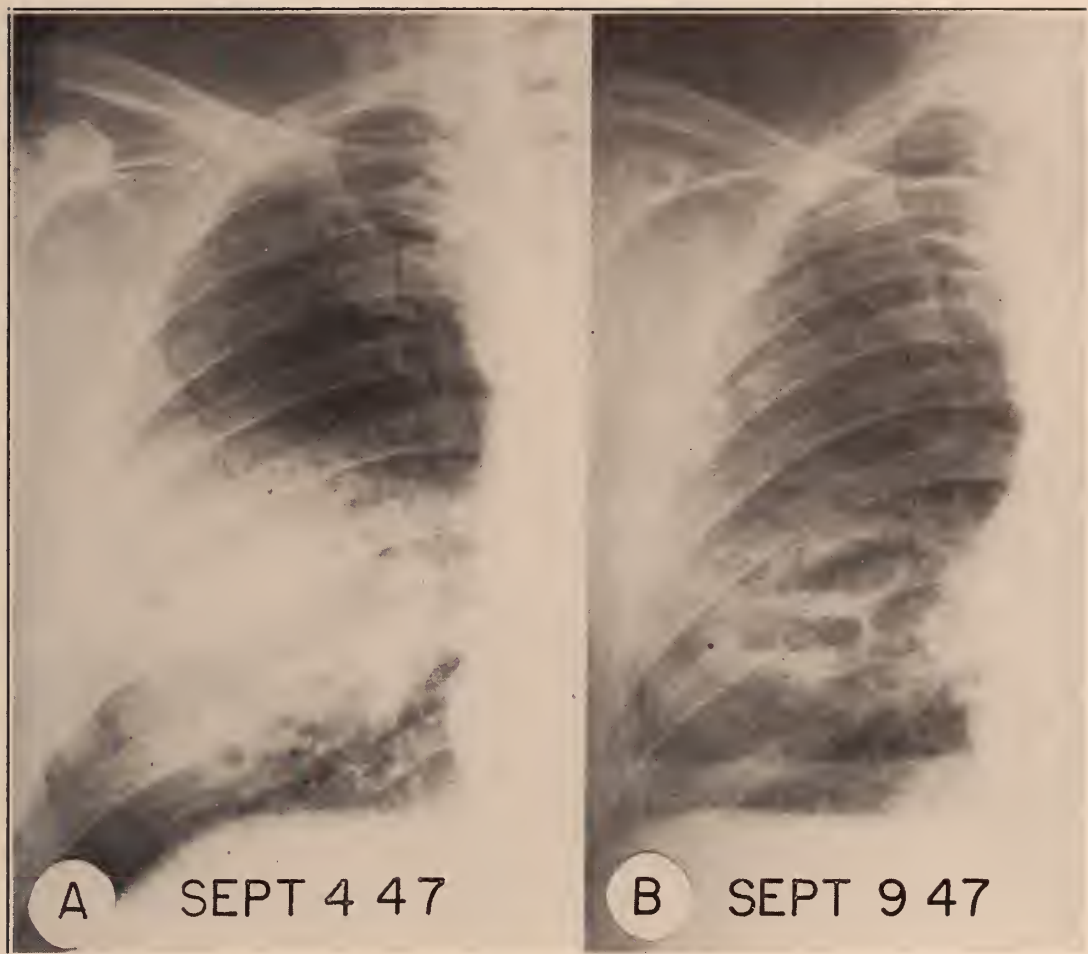


Fig. 3. Case 5. A.—Two hours after blow to chest. B.—Five days later. At least two cavities and a hydropneumothorax are shown. Examination of the ribs showed no fractures, but subcutaneous emphysema was noted. Several days later, Friedlander's organisms were recovered from the sputum.

thorax. In our case four a severe injury posteriorly produced an extensive bilateral pneumonia.

LAUCHE⁴ considers that an interval of 6 to 8 hours elapses between the time of trauma and the onset of clinically recognizable signs. Hepatization of the lung has been seen in a puppy 4 to 5 hours after experimental injury to the chest. Other authors state that pneumonia may follow trauma in 2 to 6 days. In our series, where the patients were under close observation from the time of the accident, consolidation was demonstrated within one to eight hours. None of these patients had any symptoms

of a cold, or pre-existing pulmonary disease.

Before the diagnosis of contusion pneumonia can be established, the presence of a respiratory infection antedating the trauma must be excluded. Each of the seven cases reported were seen personally and such infections ruled out.

The physical signs of pneumonia varied from complete absence (case four) to changes in percussion and auscultation. Each case showed slight to moderate temperature elevation.

Roentgenographically, there was nothing characteristic in the appearance of the consolidation. In case four, a fracture of the spine of the left scapula was demonstrated in addition

to the extensive bilateral pulmonary changes. The extent of the injuries was consistent with the force of the fall. In case five, cavities developed at the site of the consolidation, probably due to Friedlander's organisms which were recovered from the sputum.

SUMMARY

*P*NEUMONIA may occur following non-penetrating trauma to the chest wall as early as one to three hours following the injury. The lesions

may be demonstrated roentgenographically and may account for fevers in such patients. The pneumonia is usually situated beneath the site of trauma, but may occur elsewhere in the lungs. There is valid experimental evidence to substantiate this diagnosis. Clinically, pathologically and roentgenologically, contusion pneumonia does not differ from the primary pneumonias. Seven cases are reported.

I am greatly indebted to Dr. Gerald Lavner, Haverhill, Mass. for cases 5, 6, and 7.

280 Hobart Street

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Antibiotics in Bacterial Endocarditis

Results of short term antibiotic therapy of streptococcal endocarditis have recently been presented by Geraci and Martin*. Twenty-three consecutive patients with penicillin-sensitive endocarditis were treated with a combination of penicillin and dihydrostreptomycin for two weeks. Of these twenty-three patients, eighteen remained well during follow-up periods of three to twenty-four months. No treatment failures or relapses occurred in the living patients.

There were five deaths, four due to complications of endocarditis or the underlying heart disease, namely congestive failure and cerebral embolism. The fifth death was due to myocardial infarction.

Eighteen of the patients had rheumatic heart disease, three had arteriosclerotic heart disease one had luetic heart disease with aortic insufficiency, and in one case no definitive cardiac diagnosis could be made.

On the basis of this study it was concluded that one million units of aqueous procaine penicillin G plus one gram of dihydrostreptomycin sulphate given intramuscularly every twelve hours for two weeks represented adequate and curative treatment for subacute bacterial endocarditis caused by streptococci sensitive to penicillin.

*Geraci, J. E. and Martin, W. J.: Antibiotic Therapy of Bacterial Endocarditis. *Circ.* 8:494, October, 1953.

Medical Expert Testimony and Its Improvement[†]

Present-day medical testimony is defective because of out-moded legal concepts and its susceptibility to bias. Positive steps to improve this situation are presented.

DR. CHRISTOPHER C. BELING, in whose honor this lectureship was established, was a pioneer in the field of neurology and psychiatry. After several years of mental hospital experience, he turned to private practice and the development of community facilities. He directed the first psychiatric clinic in New Jersey and was one of the first to establish a juvenile clinic and bureau of mental hygiene. He was also the first president of the New Jersey Neuropsychiatric Association. His contribution to public awareness of the need for mental hygiene activities and education lives after him. As a thoughtful and public spirited physician, familiar with the forum and its ways, he shared the interest of the rest of the profession in the subject which I have chosen to treat tonight, namely, medical expert testimony and how to improve its status in the eyes of physicians, lawyers, the courts and the general public.

There are many types of legal action in which the testimony of the physician is required. One thinks, for example, of such questions as the cause of death, the degree and kind of injury in negligence cases, whether or not malpractice has been performed, the cause and extent of disability in workmen's compensation cases. In many cases of this sort the testimony

given by the physician deals with demonstrable lesions or other topics with which the layman admits readily that he is not familiar. Even in such cases we hear criticism. When, however, it comes to problems of psychiatric disability, dissatisfaction is even more widespread and severe.

THERE are several reasons why this should be the case. In the first place, the mental state of an individual is not particularly objective in the sense that, for example, an x-ray picture or a demonstration of diseased tissue is. In criminal cases, too, the public may feel that the psychiatrist is obstructing the demands of vengeance, or, as it is usually phrased, "justice." In any event it should not be forgotten that the average man in the street, although ready to admit that he does not know much about pathology, is quite ready to concede that he is fully familiar with such questions as the state of mind of a given person. If I deal largely with psychiatric expert testimony, therefore, it is merely because the criticisms are

* Superintendent, Saint Elizabeth's Hospital; Professor of Psychiatry, George Washington University School of Medicine.

† C. C. Beling Memorial Lecture, delivered at Newark, New Jersey, November 11, 1953, under the auspices of the New Jersey Neuropsychiatric Association.

somewhat more caustic and the cases somewhat more dramatic. The difference, in other words, between this kind of testimony and that of physicians in other fields is largely one of degree.

How many cases involving physicians as witnesses are tried in the courts of the United States every year no one can estimate. A few years ago Dr. Harry L. Kozol of Boston estimated that in a single year over 2100 cases involving tort were tried either before a judge or a jury in the Massachusetts courts, many of these being automobile cases. It is his estimate that probably 90 per cent of these required the participation of physicians as expert witnesses and that a substantial number of them involved psychiatrists. If we add to these other types of litigation such as those involving commitment, wills, and criminal cases, the number is certainly a large one.

IT IS not strange that the psychiatrist enters into a good many types of litigation, for after all, psychiatry, like the law, deals primarily with human behavior. Thus there are many possibilities for the testimony of psychiatrists, just as there are many for the physician in other specialties.

There is nothing new about the expert testimony of physicians. Such services to the courts have been recorded from very early times. In 1353 surgeons were called to testify before a court in England in a case involving mayhem, and in 1554 an English court expressed itself as considering it "honorable and commendable" to ask the aid of other sciences. The judges and their co-triers of the case, namely the juries, recognized the need of specialized assistance at times and were not hesitant to ask for it. They obtained it by asking the medical man to serve as an adviser to the court. Under such circumstances there was, of course, no question of competence or of bias. Indeed the statement of the medical man was taken pretty much as gospel. In 1665, for example, Sir Thomas Browne, one of the most eminent British physicians of his day, and incidentally one of the great literary figures of England as well, testified in a trial for witchcraft that "everybody

knew" there were witches and that he had no doubt that the particular women accused were indeed guilty. The two poor old ladies were executed, although we are told in the records of the case "they confessed nothing."

As recently as 1884, physicians testified in England to quite contrary opinions as to the distance which the "particles" of smallpox effluvium could travel through the air; one said 50 yards and the other thought two and one half miles. In other words, we see that experts have not always been guided entirely by scientific fact, even when they were looked upon as possessors of the truth.

THE practice, however, of obtaining expert opinions on topics which were outside the ordinary ken of laymen was very generally accepted, and Lord Mansfield, one of the great English judges at about the time of our revolution, admitted the testimony of engineers on the question of the overflow of a harbor, saying that the court should not be asked to instruct the jury on the laws of hydrostatics, and that "in matters of science the reasonings of men of science can only be answered by men of science." Of course there have been many non-medical topics in which experts were needed and as science has developed there has been a wider scope and use of expert testimony in general.

How did the present somewhat dubious state of expert testimony come about? Perhaps the most significant factor was the change in court practice after the seventeenth century by which the jury became the sole judge of the facts, the judge becoming more and more an arbiter or referee instead of sharing with the jury the responsibility of determining the facts. When the determination of fact was in part the judge's function, it was natural for him to call in experts. With this change in procedure the practice gradually evolved of having experts as well as the other witnesses produced by the parties involved.

Immediately, then, the element of partisanship, whether apparent or real, and of bias was injected into the situation, the result being that the juries could not feel the same degree of

confidence in the impartiality of the expert as they had previously. For over a hundred years comments by courts have been uncomfortably frequent relative to the unreliability of expert witnesses.

In 1843, for example, an English court said "hardly any weight is to be given to the evidence of what are called scientific witnesses; they come with a bias on their minds to support the cause in which they are embarked." A few years later, in 1870, a California court said, "it must be painfully evident to every practitioner that these witnesses are generally but adroit advocates of the theory upon which the party calling them relies rather than impartial experts."

A NEW YORK court in 1884 went so far as to say that "it is generally safer to take the judgment of unskilled jurors than the opinions of hired and generally biased experts," adding that "better results will generally be reached by taking the impartial unbiased judgments of twelve jurors of common sense—than can be obtained by taking the opinions of experts—whose opinions cannot fail to be warped by a desire to promote the cause in which they are enlisted." A Minnesota court in 1897 referred to experts as "partisan and perhaps perjured." A Kentucky court in 1916 spoke of expert testimony as the "weakest character of testimony" and added that "the expert witness . . . always colors his testimony for the side introducing him." An Ontario court in 1925 remarked that "doctors invariably disagree," while a Kentucky court as recently as 1938 stated that "efforts to eliminate the evils of bias and partisanship have not been wholly successful." It is not strange then that a French writer not long since summed it up by saying: "L'expertise mentale n'a pas une bonne presse."

Perhaps enough has been said to indicate that there has been a good deal of distrust, particularly of psychiatric testimony, and that much of it stems from the fact that the expert ordinarily is presented, that is employed, by one side or the other. For that reason courts have held that it is entirely proper to interro-

gate an expert as to how much he expects to be paid and the circumstances under which he expects to be paid. These are facts which, in the mind of the jury affect, to some extent at least, his credibility.

IT MAY be mentioned again that there are many misunderstandings on the part of the public regarding psychiatry in general and psychiatrists and their testimony in particular. A very interesting Gallup poll conducted in Louisville recently and reported by Albert Maisel (*Collier's Weekly*, May 12, 1951) indicated that certain groups, notably older persons and the legal profession, cherish some peculiar ideas about the nature of mental disease, the conduct of mentally ill persons, and what should be done for and about them.

In criminal cases, especially, a good deal of notoriety attaches to the case and of course to any defense evidence. The public is very likely to desire revenge and to look upon anyone who testifies as to mental peculiarities on the part of the defendant as "cheating" or "obstructing" justice. It is doubtful, indeed, whether the average man realizes that criminal cases form only an infinitesimal bit of the total number of actions in which psychiatric testimony plays a part. As for the question of fees, Isaac Ray, the early American writer on the legal aspects of psychiatry once remarked: "because a man's opinions are worth money it does not follow that they are corruptly bought." We shall return to this question of bias and of fees somewhat later.

IF BIAS and apparent partisanship are one reason for public distrust, there is another which is subject to perhaps more control, namely the qualifications of the expert. A New Hampshire court some years ago said: "the test to determine whether the witness is qualified as an expert is to inquire whether his knowledge of the matter in relation to which his opinion is asked is such that it will probably aid the trier of the question to determine the truth." In other words, the subject on which the expert is to testify is presumably beyond the scope of the

average individual and further, the expert is by special training or experience possessed of superior knowledge.

In earlier days the judge called in the expert not only because he trusted his impartiality but because the expert was considered to be a well-trained man competent to express an opinion which would carry weight. Nowadays in the field of medicine, however, the courts are quite ready to permit practically any holder of the degree of Doctor of Medicine to testify on any topic within the range of medicine, and courts have sustained that principle explicitly, no matter whether the physician had ever had any contact whatever with the particular field in which he is testifying. It is true that this fact of little contact might influence the weight of his evidence, but it still would not interfere with his admissibility as an expert.

In most fields of medicine courts have usually required that a person be a physician. They have specifically said, for instance, that lay witnesses are not competent to give testimony as to whether medical or dental treatment is required to effect a cure or to promote healing. In a more recent federal case the court stipulated that lay evidence on cancer is of "little or no weight."

IN SPITE of this fact, there is a growing tendency on the part of the courts to admit lay evidence on such questions as mental status and drunkenness. There are some rulings to the effect that these topics are matters which are "within the common observation of men of ordinary education and experience" and that therefore a layman is competent to express an opinion. One court, indeed, recently gave as a reason for this policy that "it is impossible to describe the actions or symptoms which constitute a basis for the opinion."

That the courts are not unanimous on this question is indicated by a recent decision which stated: "Medical science recognizes sixty pathological conditions which produce symptoms similar to those produced by alcohol, yet the law permits non-expert lay witnesses to testify on the theory that sobriety or intoxication are matters of common knowledge." This tendency

towards the use of more lay opinion on these topics is perhaps a reflection of the popular idea that the average layman knows practically as much about mental peculiarities as the psychiatrist; this attitude may be in part a reaction to the doubts which many people cherish concerning their own mental soundness!

There is certainly a great need for courts to determine criteria of expertness, and establishment of such criteria would be of great aid to trial courts. Indeed, one of the situations which led to the establishment of the American Board of Psychiatry and Neurology was the fact that some psychiatrists testified from time to time in a way that reflected no credit on psychiatry in general. It was hoped that the courts might eventually recognize the desirability of standards of competence in the field of psychiatry, just as they already do in such fields as surgery or internal medicine.

THERE is still another reason for the doubting attitude of courts concerning psychiatric testimony, and indeed to some extent to medical testimony as a whole. This depends on the naive attitude of the law in distinguishing between what it chooses to call "fact" and "opinion." The ordinary witness testifies to matters which he has observed and of which he has personal knowledge, these being euphemistically referred to as "facts." The physician, on the other hand, or any other expert may be permitted to express what is frankly an opinion on an assumed or known state of facts.

To quote a North Dakota court, however, "every result of the use of the eyesight is as a matter of last analysis a deduction or judgment." In other words, the so-called "witness as to fact" in testifying as to what he saw or what he heard is expressing a judgment and not, strictly speaking, an objective fact. It is true, likewise, as a Canadian court once remarked, that "all opinions of experts as to value reflect the idiosyncrasies of the witness. He may be an optimist," said the court, "or a pessimist; his past experiences may have been fortunate or the reverse; he may be cautious or reckless . . . The real value is almost always somewhere between the extreme opinions ex-

pressed by honest expert witnesses. Further, no one can fail to observe the tendency of the expert to become zealous for his employer. This is generally unconscious, but the distortion of the evidence is almost always unmistakable."

WE ARE all familiar with instances in which persons of very little training, who have been admitted by the judge (and this is a matter entirely in the judge's discretion) to testify as experts, have expressed opinions which are decidedly at variance with the generally accepted views of fellow specialists. Much damage has been done on occasion by the untrained or incompetent expert who may make up for his lack of knowledge by a dogmatic assurance of manner. The qualifications of the expert can, of course, be brought out on cross-examination before his testimony is accepted, but it is an incontrovertible fact that judges generally have been remiss in not insisting on adequate qualifications in the expert.

One of the features of court trials which has caused much confusion and misinterpretation has been the so-called hypothetical question. In any trial the truth or falsity of any given evidence may be passed upon only by the jury, or if there is no jury, by the judge. No witness has the right to determine which of any conflicting evidence is the fact. Consequently, the expert, when he is called upon to testify as to opinions based upon the evidence is entitled only to assume that certain facts are true. Of course, the attorney for one side, in forming a hypothetical question, is likely to utilize only evidence which favors his contention and the same is true of the attorney on the opposite side. The consequence is that the two hypothetical questions may be entirely different, although presumably they are dealing with the same hypothetical person.

COURTS do not agree as to how complete the facts assumed should be or the extent to which the judge should exert himself to make sure that a fair picture of the pertinent testimony is presented. A California court, nearly fifty years ago, remarked that the purpose of

a hypothetical question always is to frame a question so that the answer "will announce a predetermined result." The court went on to say that in the particular case involved "all perspective was eliminated, all proportion destroyed and the picture was as false to the original as is a fantastic and distorted shadow cast by a flickering and uncertain light a false portrayal of the reflected object."

Writers have criticized this type of question and Dean Wigmore referred to it as "misused by the clumsy and abused by the clever" and "resulting in an intolerable obstruction of the truth." It has been suggested as one step that the court should supervise the framing of the hypothetical question and insist that experts on both sides be asked the same question. Such procedure would be entirely within the rights of the judge. Incidentally, the length of some of the hypothetical questions which have been propounded in courts has constituted a *reductio ad absurdum*. In 1907, for example, the record seems to have been set in a will case in Boston; the question consisted of 20,000 words and consumed the better part of a day to read. Incidentally, the psychiatrist's answer was probably the shortest on record, consisting of the three words: "I don't know"!

ONE criticism leveled at experts in general is that they disagree. As a matter of fact, much of the disagreement is often based on the fact that the experts on the two sides may be asked different questions which call for different answers. We may be sure that the lawyers will see to it that any apparent discrepancies are magnified! After all, in dealing with the behavior of a given person, behavior which is conditioned by a lifetime of experiences, it is not strange that there might be room for differences of opinion, especially when the question is framed in legal terminology, a language with which the physician is not usually familiar. And assuming that the experts disagree, is that such an intolerable accusation? People disagree in many fields, and in any court case there will be discrepancies in the evidence of the witnesses, all of whom presumably are entirely honest in trying to tell the truth as they see it.

The opinions of political commentators and historians do not always agree, yet that fact is not used to discredit the whole tribe! In any court case a decision must be made that involves interpreting not only the evidence given but the general background and credibility of the persons who give it. As a matter of fact, discrepancies in the views of medical men who testify in court are usually far from being as great or as frequent as the general public believes.

Now that so much has been said about the attitudes of the public it may be commented that the physician has his attitudes, too. Many physicians object to testifying at all, and it must be said that there are good reasons why they may well do so. The atmosphere of the court room in the first place is one of combat, not that of a search for the truth. It is, indeed, a sort of game which is being played by both sides, and the atmosphere is as different as could be from that of the physician's office.

The physician wishes to have the complete history of his patient. He obtains information from other physicians, from laboratory workers and radiologists, or psychologists, yet he finds that if he uses these facts as the basis for his opinion it may be thrown out on the grounds of "hearsay." The delays of the court, too, are notorious and even though lawyers attempt wherever possible to conserve the time of a medical man, there are certain situations which are beyond their control and which result in the waste of the physician's time. On cross-examination, the physician is sometimes subjected to badgering and unfair questioning which make him feel uncomfortable. These, however, are relatively minor compared to the fact that the phraseology and the fundamental concepts of the law are far different from those with which he is familiar. We cannot expect the law to use medical language. After all, the court is one of law, and not of medicine, and the medical man is merely one type of witness. Some legal concepts, however, are based on outworn doctrines which, although once recognized, are no longer any part of scientific knowledge.

THE very word "insanity," which the courts use freely and in terms of which they expect the doctor to answer, has at least six different meanings in the law itself, viz.: incapacity to make a valid contract or deed; incapacity to draw a valid will; the degree of mental disorder sufficient to render a person not "responsible;" mental disorder of sufficient grade to render him unfit to plead; fitness for commitment to a mental hospital; or suitability for guardianship.

There is, in short, nothing unitary about the legal concept of insanity. The test of responsibility has been criticized almost since the day it was laid down in England over one hundred years ago. We know today that knowledge of right and wrong is not an adequate test of mental soundness in a criminal case and indeed the Royal Commission on Capital Punishment in a recent report has stated that the M'Naghten Rule "is so defective that the law on the subject ought to be changed."

It was not so many years ago, it may be remarked parenthetically, that the court of last resort in New Jersey had this to offer concerning the test of right and wrong; "In every jurisdiction in which the rule, that one who consciously commits a crime and knows the difference between right and wrong, has been impaired personal security and property rights have suffered." This is a defense of the "status quo" which is so weak that it has to resort to a mis-statement of fact. Actually there is little or nothing to indicate that in the states which have abolished capital punishment or in which the so-called "irresistible impulse doctrine" has been adopted, has there been any greater threat to law and order than in those states in which the hundred-year old test of responsibility is still enforced.

AGAIN in the field of delusion, the courts stick to an old, old rule which we know today is far from the fact. Although psychiatrists know that many delusions are derived from misinterpretation of actual events, the courts hold that there is no such thing as a delusion "founded on fact" and that if a person's condition "results from a belief or in-

ference, however irrational or unfounded, which is drawn from facts which are shown to exist" he cannot be referred to as suffering from an insane delusion. These are only a few examples and one might cite many others such as the fondly cherished belief in legal circles that direct identification has some special sort of sanctity. As a matter of fact many interesting studies dating from the time of Hugo Munsterberg have shown how uncertain direct identification can be.

I have, perhaps, been too detailed in my exposition of reasons why not only the physician but also the general public tend to look with some suspicion upon the methods in which expert testimony is introduced and the results which flow from it. What, if anything, can be done to improve the status of medical expert testimony?

Strangely enough, although criminal cases involving the mental state of the defendant are few compared to the total number of civil cases, the fact remains that remedies can perhaps be better applied on the criminal than on the civil side. The reason is that in a criminal case the state is not only the prosecutor but is, at least theoretically, the defender of the rights of the defendant. The state thus has a two-fold interest in seeing that justice is done, whereas on the civil side the judge sits as an umpire with relatively little control over some of the details of the trial, a trial in which the cupidity of the contestants may outrun their ethics.

IN MASSACHUSETTS the Briggs Law, enacted in 1921, provides for the automatic reference for psychiatric examination of certain persons held for trial, namely those charged with a capital offense or who have previously been convicted of a felony or indicted more than once. This law demonstrates what can be done in avoiding the battles of experts. In the first place the reference is automatic, without waiting for anyone to claim that the defendant is mentally ill. Secondly, it is made by a neutral body, psychiatrists appointed by the Department of Mental Health, and thirdly by physicians who are recognized as competent. Thus we have the question of bias and of qualifications eliminated at the start.

The British Royal Commission on Capital Punishment has recommended that in all cases of a murder charge the defendant should be examined by two psychiatrists thus adopting the general principle of the Briggs Law. The Briggs Law is by far the most important statute yet enacted which attempts to relieve expert testimony from criticism. Not only has the battle of experts been eliminated, but assurance can be given that, at least so far as the law operates, no person who is mentally unfit to stand trial will be forced to do so.

The big problem, however, is expert testimony in civil cases. In 1937, the Commissioners on Uniform State Laws under a committee headed by Dean Albert J. Harno of the University of Illinois Law School, drafted what is officially known as the Uniform Expert Testimony Act, which has also been adopted almost completely in the Model Code of Evidence proposed by the American Law Institute.

HERE is a very carefully worked out plan which was proposed to all of the states but has been accepted only by South Dakota and Vermont. Years ago, Dr. Henry Maudsley, the distinguished English psychiatrist, remarked that "our legal dignitaries have not the least desire to be helped out of their dilemma." Indeed, we are inclined to agree with him when we realize that legislation which would have done very much to solve this problem has not been generally adopted.

The fundamental principles of the Uniform Act are as follows: The court is given the authority to appoint expert witnesses either on its own motion or on the request of either party, limiting the number of experts. This is probably merely a statement of the common law right of courts if they chose to exercise it. The court then is to give notice to the parties, and the parties are required to notify the court when they call expert witnesses of their own. The court is encouraged to bring the parties to an agreement as to experts, and the witnesses appointed by the court are directed to make such examination and inspection of the person or subject matter as they deem necessary, being

given access to all persons, things or places under investigation. They then file written reports under oath, and this report may be read in court. The court may even permit or require a conference before the trial on the part of some or all of the experts, and any two or more of them may unite in a report. This report is of course subject to cross-examination. The jury may be informed that the expert has been appointed by the court. Finally the witness may be asked to state his inferences without first specifying hypothetically the data on which the inferences are based. The compensation of these witnesses is fixed by the court and taxed in the costs of the case.

This proposed act embodies the fundamental principles which we have been discussing and meets the objections to expert testimony as it now exists. The one exception is that nothing is said about lay opinion evidence. In some few courts clinics have been set up which have been useful, especially in criminal cases, but also in some civil ones. Courts, too, might very well resort more than they do to the appointment of commissions or masters or auditors, or to the use of neutral experts as do the Industrial Compensation Commissions now.

THE courts could do much to improve the status of expert testimony. The physician cannot be held entirely blameless for some of the shortcomings. However he should, first of all, be sure that he has a reasonable grasp of the problem, that he has made an adequate examination and that he has the sort of information that he would wish in making a diagnosis in his office. He should insist, wherever possible, on making a joint examination with the experts retained for the other side, although this is sometimes objected to by the attorneys. After all, the expert is acting voluntarily and does not have to accept an appointment unless his conditions can be met, but if a joint examination is made, based on the same findings and information, the likelihood of disagreement is much diminished.

Contingent fees should be entirely eliminated, that is, the physician should expect to be paid regardless of what his testimony may be

or, indeed, whether he testifies at all. Fees which are contingent upon the outcome of the case are quite obviously biased.

When in court the physician should avoid sitting at the desk of the attorney or prompting the attorney on questions to be asked of the experts on the opposing side; if he does this he should certainly not appear as a witness also. He should avoid, so far as possible, not only bias or prejudice but the appearance of them, bearing in mind his historical function as an adviser to the court rather than as an advocate.

The Supreme Court of Mississippi summed it up well some years ago in discussing expert testimony by saying, "unless all of the four elements of skill, integrity, freedom from bias and full opportunity of observation and examination under all conditions are present, such testimony is of little value and may become dangerously misleading."

IN THE case of the very few venal experts, steps should be taken by the medical societies and bar associations to see to it that persons of this sort are disciplined. The "Minnesota Experiment" appears to have worked well. Under it the state medical society appoints a special committee to review court cases in which there is medical testimony so contradictory as to indicate that one or more witnesses appeared to be consciously deviating from the truth. The judge or attorney or accusing physician submits a written statement and the transcript of the entire evidence is studied, members of the society appearing to express their opinions regarding the testimony. Steps may then be taken toward discipline. After all, one of the significant features of any profession is its internal policing. Any profession must see to it that those persons who violate the ethics of the group are duly disciplined.

In a number of law schools joint seminars are being held in which members of the medical schools join with the law students in holding moot courts or in discussing medical-legal problems. There is every reason to believe that the physician and lawyer of the future, by reason of the training they receive, will have

a better understanding of what their colleagues in the other profession are attempting to do and will gain thereby very considerably in mutual respect. Isaac Ray, over a hundred years ago, indicated the need of a higher sense of professional honor among doctors and lawyers and a healthier public sentiment, stating "to the development of those, mutual understanding will contribute much." Until such mutual

understanding and respect, already growing, become even more general we may bear in mind the other wise words of Dr. Ray, "Doctors in testifying are bound by more than the Hippocratic oath, to serve as faithful ministers of science, casting aside every ignoble prepossession born of the time and the place, and laying upon her altar the offering of an intelligent investigation and an honest purpose."

St. Elizabeths Hospital

Penicillin Reaction*

Today penicillin heads the list of therapeutic agents in the production of undesirable reactions. It has replaced foreign sera as the most common cause of fatal anaphylactic shock. It is also responsible for an increasing number of deaths due to irreversible vascular allergy, periarteritis nodosa. In most cases, however, sensitivity has been incurred unnecessarily. Moreover, the most severe sensitivities can be recognized by skin tests.

Fifteen reported anaphylactic deaths in one and a half years emphasize the seriousness of penicillin reactions. In addition to these dramatic deaths more protracted types of penicillin sensitivity have also been fatal. Exfoliative dermatitis and chronic vascular lesions have produced death. Luetic patients have at times died after penicillin-induced Jarisch-Herxheimer reactions.

Penicillin reactions occur in a variety of forms: dermatitis medicamentosa, urticaria, lesions resembling erythema nodosum and multiforme, contact dermatitis, exfoliative dermatitis, bullous dermatitis, purpuric reactions, agranulocytosis, etc.

The factors which favor penicillin reactions are sensitizing exposure, allergic constitution, the preparation itself and cross reactions with other fungi.

The treatment of anaphylactic shock due to penicillin is extremely difficult. Subcutaneous,

intramuscular and even intracardiac epinephrine, and other emergency measures were unsuccessful in preventing death in the majority of recorded fatal cases. Prevention of such serious consequences can be accomplished by the use of a tourniquet and the availability of epinephrine, Benadryl® or Pyribenzamine® for immediate injection, as well as other drugs and oxygen. When penicillin is given parenterally it should be injected into the arm at a low enough level to make a tourniquet effective. At the first sign of a severe reaction the tourniquet should be applied and kept in place to delay absorption. The airway should be kept open and oxygen administered by mouth. Epinephrine should be given by intravenous drip plus antihistaminics. ACTH may also be given by the same route.

If the reaction is less severe, penicillin should be stopped and full doses of antihistaminics and ephedrine are indicated. For exfoliative dermatitis cortisone should be given in maximum doses and the same medication is advised for periarteritis nodosa.

Most penicillin sensitivity is unnecessary and can be prevented by avoiding penicillin for minor ailments, avoiding local applications of the drug, not using depot penicillin unless decidedly necessary, using the oral route whenever possible and avoiding combination injections with possible antigens. Severe reactions also can be avoided by careful attention to an allergic history and by special questioning concerning previous penicillin reactions.

* Kern, R. A. and Wimberly, N. A., Jr.: Penicillin Reactions, *Am. J. M. Sc.*, October, 1953.

ARTHUR BERNSTEIN, M.D.
HENRY L. KUPERMAN, M.D.
FRED WEISS, M.D.
HAROLD H. GOLDBERG, M.D.
Newark

Clinical Trial of Acetyl-Digoxin*

Acetyl-digoxin, a new digitalis glycoside, was investigated and found to have no particular advantages over those already in use.

SEVERAL glycosides derived from *digitalis lanata* are now in use as purified or semi-purified substances. These crystalline preparations raised the hope that a greater uniformity of results could be achieved by standardization using chemical weight instead of biological assay. In addition, an improved therapeutic ratio† was anticipated with these purified derivatives. Whether these goals have been attained is still a matter of debate. At this time digitoxin, digoxin and gitoxin are the available glycosides. Gitoxin has been acclaimed by some to possess the unique advantage of a greater therapeutic ratio than either of the others. Digoxin was thought to be better than digitoxin because of its more rapid rate of dissipation. However, it does not exhibit any greater therapeutic index than digitoxin, and is more irregularly and poorly absorbed from the gastro-intestinal tract.

Since the cardiac lanatosides have the property of combining with modifying groups such as glucose, acetyl and 3-digitoxose, various preparations have been derived by splitting off some or all of these radicles. Thus, the genin possessing the basic nucleus is active only for

a very short period and so has been disappointing. By removing the glucose and acetyl groups from the lanatosides the well-known cardiac glycosides digoxin, digitoxin and gitoxin are obtained. Since the duration of action of these preparations is much greater than that of the genin alone, it is of interest to determine whether leaving only the acetyl group (i.e. removing the glucose and 3-digitoxose molecules from the whole lanatoside) would alter the duration of activity, absorption, toxicity, etc. (See Figure 1.)¹ The following report describes the clinical effectiveness of such a preparation, acetyl digoxin, a derivative of lanatoside C.

Pharmacologic data concerning this compound indicated that this substance is more consistently absorbed from the gastro-intestinal tract than lanatoside C or digoxin, apparently being similar to that of digitoxin.²

SELECTION OF PATIENTS

TO EVALUATE acetyl-digoxin clinically, nine ambulatory clinic patients with auricular fibrillation were chosen. Prior to this study three of these patients were not on any digitalis preparation, while six had been taking either Digilanid® or a digitalis whole leaf prepara-

* From the Cardiac Clinic, Newark, Beth Israel Hospital.

† The therapeutic range or index may be expressed as a percentage ratio between the amount of the digitalis preparation required for a therapeutic effect and the total dose required for toxicity.

DIGITALIS LANATA

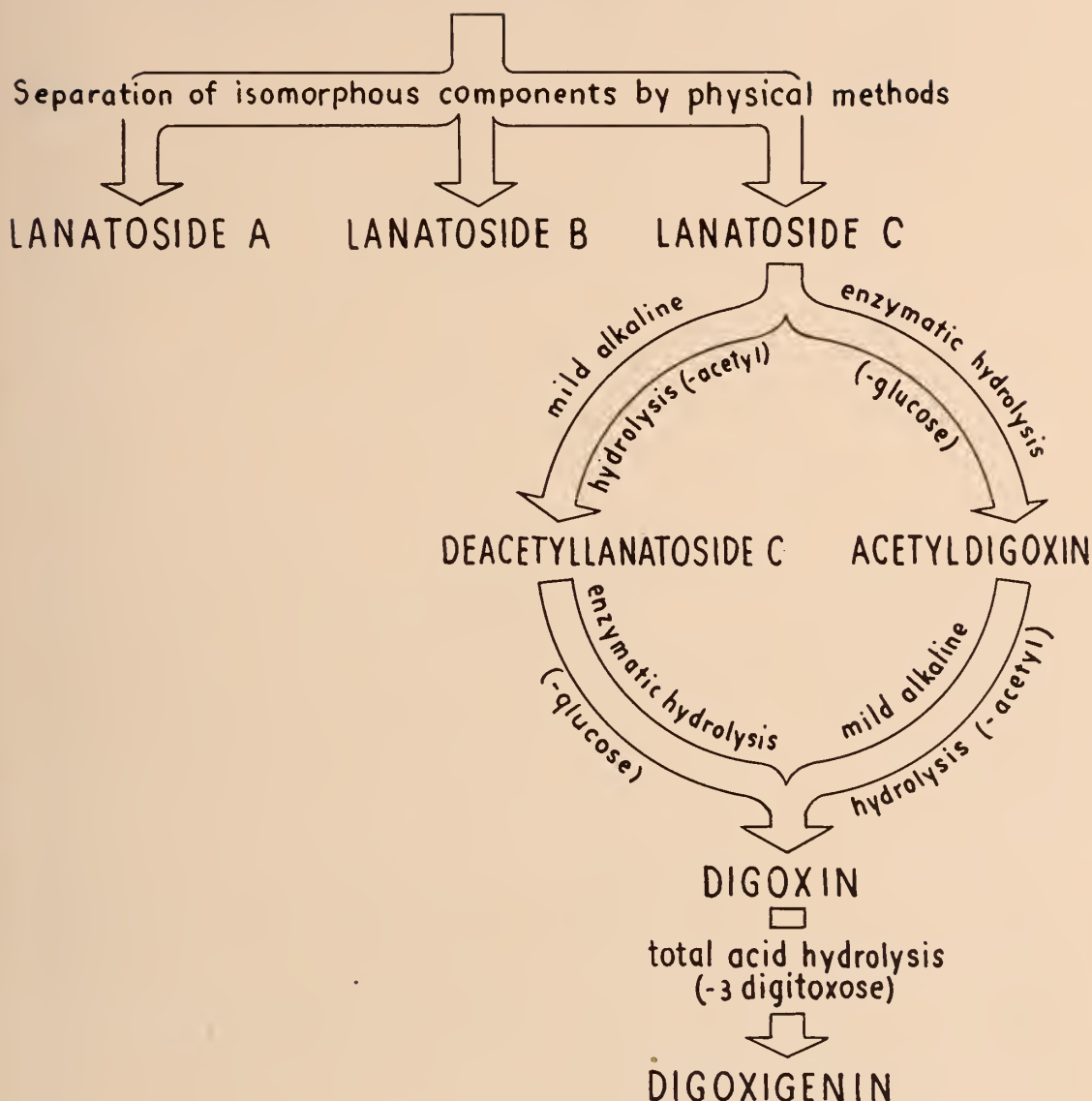


Figure 1.

tion. Five patients were receiving mercurials by injection in addition to the digitalis. (See Table 1).

MATERIALS AND METHODS

SINCE we did not know the maintenance dose of this drug in man we started with an arbitrary dose of 0.1 or 0.2 milligrams daily in those patients who were previously on maintenance digitalis. Those who were not already

taking digitalis were started with larger initial doses. The effectiveness of the drug was determined on the basis of the ventricular rate and exercise tests. The dose was increased or decreased as indicated.

In determining the effect of exercise on the ventricular rate in patients with auricular fibrillation, a modification of the LaPlace³ and the Modell⁴ technic was employed. The ventricular rate was counted by auscultation for one minute after the subject had rested in the

TABLE 1. SUMMARY OF DATA

Patient Information				Previous Medication			Observation		Final Dose	Results
Case	Age	Sex	Diagnosis	Mercurial	Drug	Daily Dose (mg.)	Duration	Period (in months)	of Acetyl-Digoxin	
1.	60	M	A;EH;AF	No	None	—	—	4	0.5 mg.	Good
2.	77	M	HA;EH;AF	Yes	D	0.333	7 mo.	10	0.4 mg.	Good
3.	65	M	HA;EH;AF LBBB	No	D	0.999	1 wk.	10	0.5 mg.	Good
4.	58	M	A;EH;AF	Yes	None	—	—	5	0.2 mg.	Good
5.	70	M	A;EH;AF	No	DWL	100	8 mo.	11	0.5 mg.	Poor by exercise test
				No	D	0.333	19 mo.			
				No	D	0.666	17 mo.			
6.	38	F	R;MI;MS; EH;AF	Yes	D	0.333	3 mo.	10	0.6 mg.	Poor— rate and failure not controlled
7.	65	M	A;C;AF	Yes	DWL	100	6 wk.	6	0.5 mg.	Poor— nausea and diarrhea
				Yes	D	0.333	3 wk.			
8.	60	F	R;MI;MS; EH;AF	Yes	D	0.666	3 wk.	5	0.9 mg.	Poor— rate and failure not controlled, frequent palpitation and rapid ventricular rate
				Yes	D	0.999	3 wk.			
				Yes	D	0.666	17 mo.			
9.	67	F	HA;EH;AF	No	None	—	—	10	0.6 mg.	Poor by exercise test

A—arteriosclerotic heart disease

EH—essential hypertension

AF—auricular fibrillation

HA—hypertensive and arteriosclerotic heart disease

LBBB—left bundle branch block

R—rheumatic heart disease

MI—mitral insufficiency

MS—mitral stenosis

C—cor pulmonale

D—Digilanid

DWL—Digitalis whole leaf

sitting position for 30 minutes. He then walked ten times over a two-step staircase. (Each step was nine inches high and built according to Master's⁵ two-step specifications). No set rate for walking these steps was specified; each patient selected his own pace. After walking the steps, the patient returned to his chair. The ventricular rate was counted at 15 second intervals for a period of three minutes from the moment he sat down. We agree with LaPlace's³ statement that the ventricular rate during the first 15 seconds after exercise is the same as the maximum rate during exercise. This is usually called the "maximum exercise rate." It is important to note, as did Modell,⁴ that the patient with auricular fibrillation has acceleration of the ventricular rate during exercise chiefly, if not entirely, because of a decrease in vagal tone. Modell⁴ and Parsonnet

et al.,⁶ observed in exercise tolerance experiments that the ventricular rate in patients with auricular fibrillation will not rise appreciably beyond 100 beats per minute if the patient has been fully digitalized (because of both vagal and extra-vagal mechanisms).

RESULTS

THE effects of acetyl-digoxin were observed in these nine patients for periods of 4 to 11 months (Table 1). The final daily maintenance dosage ranged from 0.3 to 0.9 mg. (Table 2). The results of exercise tests and maintenance dosage of acetyl-digoxin at the time of testing is shown in Table 2. Good digitalis effect was obtained in 4 patients.

A resume of our observations in three selected cases follows.

TABLE 2. EXERCISE TESTS WITH ACETYL-DIGOXIN

Case	Resting Rate Sitting	Maximum Exercise Rate	Rate During 1st Min.	Rate During 2nd Min.	Rate During 3rd Min.	Dosage of Acetyl-Digoxin at Time of Test
1.	76	104	94	85	80	None
	78	90	88	86	86	0.5 mg.
2.	82	116	108	90	83	None
	64	96	91	82	72	0.4 mg.
	66	88	78	70	67	0.4 mg.
3.	68	100	96	84	78	0.5 mg.
	52	88	76	64	57	0.5 mg.
4.	60	84	72	64	60	0.2 mg.
5.	84	104	93	84	84	0.4 mg.
	82	112	96	80	80	0.5 mg.
9.	74	108	102	88	80	0.4 mg.
	74	132	116	101	89	0.5 mg.
	88	136	118	98	92	0.5 mg.
	88	140	114	99	94	0.6 mg.

CASE REPORTS

No. 1. A 60-year old white male with arterio-sclerotic heart disease and an enlarged heart had not been digitalized. His ventricular rate was 76 per minute. However, an exercise tolerance test (Figure 2) demonstrated a maximum exercise rate of 104. He was digitalized with acetyl-digoxin 1.2 mg., over two days and then given 0.4 mg. daily for one month. His ventricular rate at this time was 84 per minute. The dose was then increased to 0.5 mg. and he was maintained on this for three months. His ventricular rate at the end of this time was 78 per minute and an exercise test demonstrated a maximum exercise rate of 90 per minute. It was felt that he was now sufficiently digitalized to achieve maximum vagal and extra-vagal effects.

No. 3. A 65-year old white male had hypertensive and arteriosclerotic heart disease with an enlarged heart and left bundle branch block. He had been slowly digitalized with Digilanid®, 0.999 mg. daily, for one week before coming under observation for this experiment. His ventricular rate was 54 per minute but he showed no signs of digitalis toxicity. He was switched to acetyl-digoxin, 0.2 mg. daily, and in three weeks his ventricular rate rose to 80. The dose was gradually increased to 0.4 mg. daily and he was maintained on this for two months. The ventricular rate during this time varied from 62 to 88 per minute. The dose was then increased gradually to 0.6 mg. and after one month on this dosage, the ventricular rate dropped to 52. There were no signs of digitalis toxicity even with this slow rate. The dose was then decreased to 0.5 mg. and he was maintained on this dose for three and one half months. An exercise test at the end of this time showed a resting ventricular rate of 69 per minute and a maximum exercise rate of 100. This dose of 0.5 mg. seemed to be sufficient and adequate for complete maintenance.

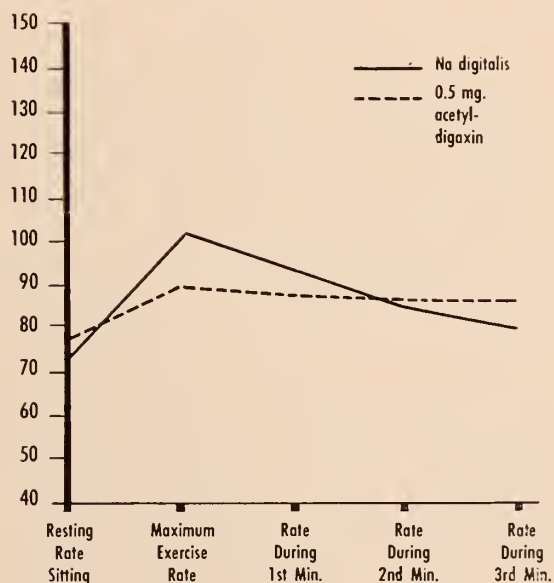


Figure 2. Case 1.

No. 5. A 70-year old white male with arterio-sclerotic heart disease and heart enlargement had been maintained with Digilanid® 0.666 mg. daily and had a ventricular rate of 76 per minute. He was transferred to acetyl-digoxin 0.2 mg. and in one month the ventricular rate rose to 88 per minute. The dose was gradually increased to 0.4 mg. This was continued for 4 months during which the ventricular rate varied from 80 to 90. An exercise test was done and showed insufficient digitalization with a maximum exercise rate of 104 per minute. He was then given 0.5 mg. for 2 months and a repeat exercise test still showed insufficient digitalization.

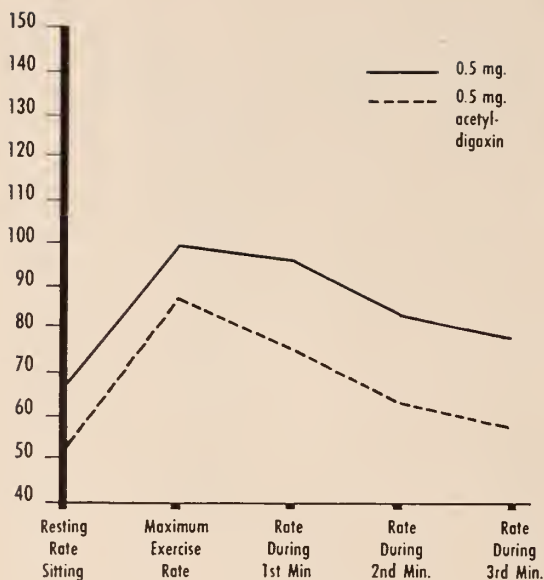


Figure 3. Case 3.

DISCUSSION

A SATISFACTORY therapeutic response was noted in 4 patients. Two cases (numbers 5 and 9), had resting ventricular rates between 80 and 90. After an exercise test the ventricular rate exceeded 100, indicating that 0.5 or 0.6 mg. of acetyl-digoxin per day for several months failed to produce an effective response. In two cases (numbers 6 and 8), the resting ventricular rate and congestive failure could not be controlled on maintenance doses of 0.6 and 0.9 mg. of acetyl-digoxin respectively. In one case (number 7), the drug had to be discontinued when a dose of 0.5 mg. was reached because of nausea and diarrhea. However, no other signs of digitalis toxicity were observed. The patient was not controlled by a smaller dose.

Although it would seem from these studies that acetyl-digoxin is far from an ideal preparation and does not meet several of the criteria listed by Batterman, Holman and DeGraff,⁷ it is only fair to say that it may have been possible to achieve better results if we had been able to increase the dosage to higher levels. However, the dosage level was limited by patients' objections to such a great number of tab-

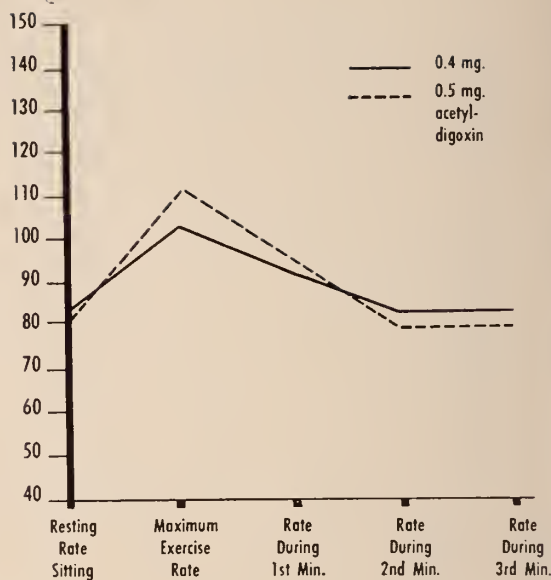


Figure 4. Case 5.

lets. Even though this is not an ideal drug, it was therapeutically effective in some patients. However, from our studies, as well as those of Enselberg, *et al.*⁸ it is obvious that this preparation has no particular advantages over those already in use, in spite of its great promise in the laboratory.

SUMMARY AND CONCLUSIONS

A NEW digitalis preparation, acetyl-digoxin, is a glycoside derived from digitalis lanata. It was evaluated clinically in nine ambulatory patients with auricular fibrillation to determine optimum dosage and its effect on ventricular rate. It was able to exert satisfactory digitalis effect on both vagal and extra-vagal mechanisms in four of the nine patients. In five of the nine patients its effect was unsatisfactory.

The average daily maintenance dose of acetyl-digoxin is in the neighborhood of 0.4 to 0.6 mg.

It has no particular advantages over the glycosides now in use in spite of its laboratory promise.

The authors wish to thank Drs. Sanford Lewis, Franklin Simon and Emanuel Klosk for their help with some of these studies.

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Primary Cardiac Amyloidosis*

Amyloidosis has been classified in four general groupings: 1) Secondary amyloidosis, associated with pre-existing disease, such as tuberculosis or chronic suppuration; 2) primary amyloidosis; 3) amyloidosis associated with multiple myeloma; and 4) tumor forming amyloidosis.

In secondary amyloidosis, amyloid is distributed typically in the liver, spleen, kidneys and adrenals. In primary amyloidosis the distribution is less frequent in these organs and more common in the heart, tongue, gastro-intestinal tract, lungs, smooth and skeletal muscle, skin and lymph nodes. Six to ten per cent of multiple myeloma cases show an amyloid deposition resembling the primary type. The least common form is tumor-forming amyloidosis which occurs as localized masses in the skin and various mucous membranes.

Cases showing amyloid in the myocardium raise the question as to whether these do not represent a separate category. Factors in favor of this concept are: 1) Primary cardiac amyloidosis occurs in an older age group than systemic primary amyloidosis. 2) Although extensive myocardial infiltrations with amyloid are seen in the systemic form there is also considerable amyloid deposition elsewhere. This distribution differs from that of the primary cardiac type in that extracardiac amyloid is either totally absent or present in very small amounts in alveolar walls, small vessels or other places. 3) In view of the present confused status of amyloidosis in general, a separate

category for the primary cardiac form may be useful in future investigation.

Clinically the diagnosis of cardiac amyloidosis is difficult to establish. In the literature it is stated that persistent congestive failure in an aged individual that fails to respond to therapy (in the absence of other causes) should lead one to suspect cardiac amyloidosis. However, congestive failure only occurs in one half of all cases and is resistant to therapy in only the more severe. Moreover, hypertension and arteriosclerosis occur in twenty per cent of primary cardiac amyloidosis patients. In addition, some valvular lesions have been reported as a result of amyloid infiltration.

No characteristic electrocardiographic pattern has been found for this disease. The only laboratory procedure of any value is the Congo red test, but it is positive in less than one half of the cases in which it has been performed. In ten per cent of the patients there has been an elevated serum globulin.

In systemic primary amyloidosis there is usually involvement of the skin, tongue or other superficial tissues permitting a biopsy to reveal the diagnosis. Unfortunately this is not available in the primary cardiac type.

At present treatment of primary cardiac amyloidosis must be restricted to the usual measures for dealing with heart failure as no specific therapy has been found.

* Thomashow, A. I., Angle, W. D. and Morrione, T. G.: Primary Cardiac Amyloidosis. *Am. Heart J.*, December, 1953.

Transorbital Lobotomy in State Mental Hospitals*

Transorbital lobotomy is a simple, effective method of treatment. It offers hope of returning a relatively high percentage of "incurable" psychotics to their communities.

IN THE 18 years since Egas Moniz¹ introduction of lobotomy there has been ample time for exploring the different ways of accomplishing better results, and for long-range follow-up studies to determine the eventual fate of patients. The facts are available. However, there is no procedure in the whole field of medicine that has stirred up as much controversy as psychosurgery. While it is essential to have an assessment of the moral, ethical and legal aspects of such a therapeutic procedure, the prolongation of such discussions accomplishes little. Meanwhile, thousands of patients are added annually to the rolls of state hospitals. This, added to the personal distress, anguish and disability of the patient as well as the hardship to his family should stimulate us to look at the problem from the viewpoint of the state mental hospital.

These are some of the facts that have been assembled from large scale investigations.

1. One third of apparently incurable hospitalized psychotics can be returned to their homes. These are run-of-the-mine cases.

2. At the end of a 10 to 17 year period half of the discharged schizophrenics, and almost all of those with neurotic and affective disorders are still carrying on an effective existence.²

3. Lobotomized patients seldom come in conflict

* From the Department of Neurology and Neurological Surgery, George Washington University.

Presented at the Workshop in Psychosurgery, New Jersey State Hospital, Marlboro, on October 29, 1953.

with the law. In spite of the presence of some twenty thousand patients (out of 50,000 lobotomized) in the community, the question of lobotomy has not yet been brought up in court in connection with the question of responsibility.

4. Lobotomy, instead of being the last resort in therapy, is often the starting point in effective therapy.³

5. While lobotomy is still troubling the conscience of many people, both lay and professional, the balance of opinion favors the operation on the principle, as enunciated by the Supreme Pontiff,⁴ that a part may be sacrificed for the benefit of the whole.

WITH these basic points adequately considered, it seems not only possible, but obligatory, to extend the program of psychosurgery into the state mental hospitals in an effort to relieve human misery. When that misery is relieved, there will appear as a by-product an extraordinary alteration in the whole character of the hospital.

Through the efforts of Dr. S. O. Johnson, Superintendent of Lakin State Hospital, Lakin, West Virginia, one tenth of his patients were operated upon in 1952 and another tenth in 1953. The discharge rate of these lobotomized patients was over 50 per cent. One of the most affecting scenes in my experience occurred there in the summer of 1952. When I returned to the hospital a week after performing 20 transorbital lobotomy operations, I

found a group of 15 of the 20 lobotomized patients out on the grounds, with one attendant in charge of them. I learned that these patients were outside of the disturbed unit for the first time in from six months to seven years.

These figures show what can be accomplished by energetic application of lobotomy in the average state mental hospital. When it is considered that there is a large back-log of patients who, because of age or deterioration, cannot be considered candidates for lobotomy, the figures take on added meaning. Lobotomy can change insane asylums into old peoples' homes.

WHAT OPERATION?

SINCE the work of Moniz and Almeida Lima, approximately thirty different operations on the brain have been proposed for the relief of mental disorder. Only one of these, transorbital lobotomy, can be applied effectively under conditions in state hospitals where there is a shortage of everything but patients. This operation is simple, safe, precise and effective. It lends itself well to performance with a minimum of trained personnel. It is followed by prompt surgical recovery. Many patients can be sent home within a week, while the family interest is still high. In a major study,⁵ I found that this operation cuts the mortality in half, and reduces complications, such as convulsions, incontinence, obesity and the frontal lobe syndrome by 95 per cent. Transorbital lobotomy is the operation of choice in state mental hospitals.

WHO SHALL OPERATE?

THE proponent⁶ of the transorbital method,

Fiamberti, is a psychiatrist. The great majority of transorbital operations have been done by psychiatrists. The mortality and morbidity experience of these operators has been gratifyingly and consistently low. The psychiatrist is in a position to know the needs of his patients, to give the necessary care before and after operations and personally to confer with the families concerning the rehabilitation of patients after discharge.

The only legal qualification is the possession of a license to practice medicine and surgery in the state where he is employed. There has been no crystallization of official action on the part of the various states. This is fortunate, since programs in some states are already hampered by excessive restrictions. The policy of the Virginia State Hospital Board in regard to the performance of lobotomies may be cited as a reasonable compromise that assures the maximum protection to the hospital and the maximum freedom to the operator. Under this program there have been 185 patients operated upon by me or under my direction, with 3 operative fatalities, and 81 releases from the hospitals (44%).

The State Hospital Board at its meeting held in Richmond on January 8, 1953, adopted the following as a policy in regard to the performance of lobotomies at the several state hospitals.

RESOLVED: that it shall be the policy of the Department of Mental Hygiene and Hospitals to authorize transorbital lobotomy operations in the State's mental hospitals (including DeJarnette State Sanatorium, but not the colonies), under the following conditions:

1. No patient shall be approved by the hospital superintendent for this operation unless the patient has been mentally ill for at least two years, has failed to respond satisfactorily to psychiatric treatment, including shock treatment if indicated, and the transorbital lobotomy has been requested and/or approved by the closest of kin.
2. The operation shall be performed only by a physician with established competence in this field of neurosurgery, or by a physician of established competence acting under the direction of such neurosurgeon.
3. The operation shall be performed only in an approved surgical facility of the State's mental hospitals and sanatorium as certified by the Commissioner of Mental Hygiene and Hospitals.
4. No lobotomy operation shall be performed without approval of the Commissioner of Mental Hygiene and Hospitals or by an outside psychiatrist designated by him.
5. Contract neurosurgeons may be retained for transorbital lobotomy operations only to the extent that a hospital's appropriation for such services makes possible, after due allowance for other surgical and specialists' services which might normally be required during a fiscal year.

SUMMARY

TRANSORBITAL lobotomy can be used effectively in state mental hospitals with the expectation of relief of a vast amount of human misery and the return to effective existence of one third of apparently incurable patients.

Ten per cent of patients per year are candidates for lobotomy.

Transorbital lobotomy should be performed by the psychiatrist, his necessary legal qualifications being the possession of a license to practice medicine and surgery in the state where he is employed.

2014 R Street, Northwest

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Chronic Aorto-Iliac Thrombosis

Intermittent claudication is the most common symptom of occlusive arterial disease of the lower extremities. It occurs in almost all patients with arteriosclerosis obliterans and in 75 per cent of those with thrombo-angiitis obliterans. Intermittent claudication is commonly thought of as pain or fatigue in the calves which occurs after walking a specific distance. This pain is severe enough to require the patient to stop. It then subsides in two to five minutes and the patient can walk approximately the same distance again before the pain returns.

Intermittent claudication is not necessarily confined to the calf; it can occur occasionally in the foot or the thigh. However it is not widely known that areas proximal to the thigh such as the hip, buttock and low back may participate in this syndrome.

During the past five years forty-seven patients with intermittent claudication of the hip have been seen at the Cleveland Clinic.* The syndrome occurs in relatively young persons, particularly men between forty and sixty years of age, and is due to localized arteriosclerosis

of the terminal aorta and iliac arteries. Signs and symptoms of generalized arteriosclerosis are usually absent. The symptoms consist of intermittent pain, on walking, in the hip and hip area which includes the thigh, low back and low abdomen. In approximately 40 per cent of cases the calf is also involved. In only one case was impotence found.

Aortography is the most important diagnostic aid. It is easily done and causes little complications. Information is obtained as to the site of the block and the degree of collateral circulation. In general, aortic and common iliac artery occlusions are associated with the most efficient collateral circulation. External iliac occlusion, on the other hand, is associated with poor collateral blood flow.

Of the forty-seven cases in this series seven had thrombosis of the abdominal aorta, eleven of one common iliac artery, four of both common iliac arteries, two of one external iliac artery and one of one common iliac artery and the opposite external iliac arteries.

Conservative treatment with frequent observation is recommended. Endarterectomy, or resection combined with sympathectomy, or sympathectomy alone are unsatisfactory. Over a long period of time there is little indication that the disease is chronically progressive.

* DeWolfe, B. G., et al.: Intermittent Claudication of the Hip and the Syndrome of Chronic Aorto-Iliac Thromboses. *Circ.* 9:1, Jan. 1954.

Allergic Manifestations of Dental Infection

Three cases of skin allergy which responded to appropriate dental treatment lend support to the concept of a focus of bacterial sensitivity.

FOCI of infection have been the subject of a voluminous discussion in medical literature.¹⁻⁸ Opinion has differed widely on the importance of focal infection and bacterial sensitivity in the production of allergic syndromes and other secondary disease states.

Reactions of organs remote from a focus of infection need not necessarily arise from transported bacteria but more likely from humoral reactions of the body such as anaphylaxis or allergy. Apparent cures of allergic syndromes by the extraction of infected teeth are best explained by the elimination of a center of sensitization rather than of a center of spreading bacteria.⁹ Thus, the term "center of sensitization" would be more appropriate than focus of infection.

The wide vogue which the theory of focal infection held thirty or forty years ago^{1,2,3} has been somewhat discredited in the past two decades.⁷

Against the strong reaction to the principle of bacterial hypersensitivity, there have appeared several recent reports^{7,8,10-14} supporting its validity.

Three cases reported here lend support to bacterial hypersensitivity as a clinical entity.

CASE REPORTS

No. 1. A 39-year old white female presented herself on December 15, 1949 with complaints of itchiness and a rash on the eyes and neck of one month's dura-

tion. Therapy with topical medication and oral and parenteral antihistaminics was ineffective.

The patient had hives as a child, and ulcerative colitis ten years earlier (now inactive). In her teens she had inflammatory rheumatism in the left hip. She gave a history of allergy to perfume and lipstick.

Examination showed a pruritic, reddened, eczematoid, macular lesion of the neck and right eye.

Skin testing with a large number of allergens gave inconclusive results. A bacterial sensitivity was suspected and the patient referred for dental examination.

The dentist reported an impacted upper right bicuspid and apical infection of the lower right second bicuspid and lower left lateral incisor.

On December 30, 1949, the impacted tooth and three other infected teeth were removed along with a small infected dental cyst.

By January 9, 1950, healing of the skin lesions was complete and to date there has been no recurrence.

No. 2. A 70-year old white female was seen on January 10, 1952, with chronic eczema of six years' duration which had become worse in the past two years. She had been subjected to extensive prior investigation and study.

Physical examination showed papular, excoriated, eczematoid lesions involving the hands, face and neck with considerable localized edema. The appearance was compatible with an allergic dermatosis.

The blood contained an eosinophilia of ten per cent.

Antihistamines and elimination of allergenic foods failed to produce any substantial improvement. A dental examination showed infection throughout the mouth. Complete dental extraction was accomplished and within one week the patient exhibited practically complete clearing of all the lesions.

Since that time she had recurrences of her lesions of relatively minor degree. She has had none

It is believed that this patient had multiple allergies, the most important of which was to the bacterial proteins of her infected teeth. The minor recurrences may be attributed to one of the foods giving a positive reaction.

No. 3. A 46-year old white male was seen on October 10, 1949, with a complaint of difficulty in breathing. Following a heavy cold in 1948, the patient noted progressive increase in exertional dyspnea, waking up in the morning "all filled up with mucus." These complaints were worse in his bedroom or after eating pork. A brother had asthma.

Examination showed wheezing typical of asthma. A chest x-ray showed moderate emphysema. The blood count revealed a 10 per cent eosinophilia.

A trial course of therapy with elimination diets and medication produced no noticeable improvement.

A dental examination showed a generalized chronic gingivitis. X-rays revealed areas of infection with horizontal bone resorption. The lower right molar had periapical involvement. The upper left third molar was horizontally impacted. All teeth were extracted and purulent exudate was found. These areas were curetted and drained.

The extractions were completed on November 7. Eight days later, the patient stated that, although he had some cough, the wheezing had practically disappeared.

In reply to a letter of inquiry concerning his present status, he writes, "I can't recall the exact date I got relief. It was soon after all my teeth were pulled. I still have mild attacks of asthma now and then but nowhere near as bad as before."

A DENTAL report which includes any of the following conditions should alert the physician to the possibility of a center of sensitization in the oral cavity: gingivitis, gingivo-stomatitis, pulpitis, infected root canals, painful vital but infected pulps, periodontal infections, periodontitis, alveolar abscess, apical and periapical infection, partially impacted teeth, retained roots, residual infections of bone after extraction, infected cysts, osteomyelitis of the jaw and infected salivary calculi. Any of these may be responsible for an allergy.¹⁵

Despite this apparent emphasis on the role of the dentist, it is not to be concluded that dental infection is the major factor in a case of allergy or even in the general field of foci of infection. Only if the etiology is not discernible after thorough investigation should the dentist be called in to determine the possibility of such a focus.

CONCLUSIONS

THE validity of bacterial hypersensitivity in the etiology of the allergic manifestations in certain cases is supported.

Specific case histories are cited to illustrate this hypothesis.

151 West Commerce Street

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Oral Polymyxin B

Pseudomonas aeruginosa (*Bacillus pyocyaneus*) was first identified in 1882. Since then this organism has been shown on several occasions to be responsible for infantile diarrhea. In several instances fatal cases have been reported.

In a recent communication from the pediatric research division of the Michael Reese Hospital in Chicago, Mills and Kagan* have found this organism in the stools of carriers and some patients with gastro-intestinal symptoms.

Of 273 hospital personnel examined, 32 had stool cultures positive for *P. aeruginosa*. Twenty-four of these were treated with Polymyxin B and eight served as controls.

Of the control cases none had gastro-intestinal complaints. Fifty per cent of these asymptomatic carriers were spontaneously free of this organism in follow up studies 25 and 38 days later.

One hundred and fifty milligrams of Polymyxin B were given orally every eight hours for seven days to the treated asymptomatic group. Stool cultures were repeated 25 and 30 days after the drug had been started. At this time only one remained positive for *Pseudomonas*. Nine of these patients had gastro-intestinal symptoms: one had abdominal cramps, one had recurrent episodes of diarrhea, three had acute diarrhea and four complained of cramps and diarrhea. Following treatment with Polymyxin B all of these nine were relieved of their symptoms and in addition all of their stool cultures were negative for *Pseudomonas* after five days of treatment. In the follow up group only one of twenty-three individuals continued to have *Pseudomonas* present after one week's treatment with Polymyxin B. In addition, there was striking symptomatic relief fol-

lowing the use of this drug and clearing of the organism from the stools.

P. aeruginosa may inhabit the bowel and produce no symptoms, it may also disappear without therapy. However in fifty per cent of the cases it remains for at least one month. In other patients it advances from the gastro-intestinal tract by invasion of neighboring tissues via the blood stream and may cause serious and sometimes fatal illness.

When present in the intestinal tract in large numbers it can become a pathogen. It may perforate the bowel wall or produce metastatic infection of the kidneys, central nervous system or other organs. It is also possible that the organism may spread from carriers to newborn infants in nurseries. It is thus possible that epidemic diarrhea of the newborn may be due to this bacteria. It can be transmitted not only by feeding procedures but also by many preparations, such as boric acid, normal saline, acriflavine and penicillin. Polymyxin B is a reliable drug for the control of such outbreaks.

It is also clear that the commonly used antibiotics, particularly Terramycin® or the sulfonamides, may clear other organisms from the bowel leaving *Pseudomonas* as the only inhabitant. This may be eliminated by additional treatment with Polymyxin B.

Polymyxin B should be considered promptly as a control measure in any outbreak of diarrhea in a nursery for newborns where *Pseudomonas* is found as the most likely pathogen. It should also be considered as a prophylactic measure in personnel who harbor this organism.

* Mills, G. Y. and Kagan, B. M.: Effect of Oral Polymyxin B on *Pseudomonas Aeruginosa* in the Gastro-Intestinal Tract. Ann. Int. Med. 40:26, Jan. 1954.

Puerperal Intestinal Obstruction Following Appendectomy

Two cases of intestinal obstruction occurring during the puerperium and following appendectomies are reported. A possible mechanism for this rare postpartum complication is proposed.

Two cases of puerperal intestinal obstruction seen in eight months has aroused the suspicion that this particular type of obstruction may be one of the hazards of the puerperium. The recent literature reports only two cases of postpartum intestinal obstruction in the past 20 years. Henkin¹ described a case due to a congenital adhesive band between the cecum and the lateral peritoneal wall. Woodruff and Ep-person² reported a case in 1952 practically identical with those described in this paper. The sequence of events noted here is not described in Wangenstein's *Intestinal Obstructions*.³

CASE REPORTS

No. 1. A 28-year old woman was admitted on February 7, 1953, and after fourteen hours of uncomplicated labor she was delivered by outlet forceps and episiotomy of a living male infant. Her puerperium was normal for the first two days. About 4:00 p.m. on her second day she experienced rather sharp lower abdominal pain and soon vomited a large amount of partly digested food. This was followed by a comfortable night, with a recurrence of pain and vomiting at 5:00 a.m. An ineffectual enema was given at this time. Physical examination was negative, and there was no leucocytosis. A comfortable day followed, with only one emetic attack. The following morning, however, (36 hours after her original attack) pain and vomiting returned and for the first time mild distention occurred with visible peristalsis. An x-ray examination revealed a distended loop of jejunum but no other positive findings. As the patient's condition

became worse, laparotomy was performed. A large part of the small bowel was found in early strangulation under a thin fibrous band running from the head of the cecum to the posterior peritoneal wall. This band was about two inches in length, and its severance quickly restored circulation and patency to the strangulated bowel. Recovery was complete and uneventful.

The patient's medical history included an appendectomy seven years prior to this illness.

No. 2. A 24-year old female had a spontaneous delivery on September 8 1953, after a short uncomplicated labor. On September 29, 1953, at 2:00 p.m., she developed severe lower abdominal pain followed in a short time by vomiting. The day before this she had taken a laxative and had two normal bowel movements. On admission she was examined and found to have no distention, but did have foul lochia, a uterus only slightly enlarged, and marked adnexal tenderness on both sides. Her temperature was 100 degrees F. and her white blood count 28,000. She was thought to have a parametritis. Sedation was given with parenteral fluids and antibiotics. Next morning the patient appeared extremely ill and a distinct mass, the size, conformity and consistency of which suggested a five months' pregnant uterus, was felt by the physician. A flat plate of the abdomen showed probable intestinal obstruction. Examination was difficult because of the pain, but a normal uterus was identified, and was distinct from the mass above. The white blood count was now 57,000. Immediate laparotomy was carried out. The mass was composed of omentum and distended loosely adherent loops of strangulated small intestine. A thin fibrous band from the appendix scar to the posterior peritoneal wall was found with distention above and collapsed bowel below. On severance of this band, the strangulated intestine showed signs of viability and was re-

turned to the abdominal cavity. Convalescence was uneventful. Her medical history included an appendectomy fourteen years ago.

DISCUSSION

THE remarkable findings in both of these cases was the presence of a fibrous band between the appendix scar and the posterior abdominal wall, the band in both cases being about 5 centimeters in length. The pathogenesis may be that the enlarging pregnant uterus pushes the bowel, especially the colon, higher into the abdominal cavity, and in so doing stretches the short fibrous adhesion between the appendix stump and the posterior abdominal wall. Following delivery, the bowel returns to its normal location; but now a loose strand

of tissue is present, inviting herniation of the small bowel through it, and possible strangulation. If indeed this is the mechanism involved, this type of obstruction is clearly a hazard of the puerperium in women who have had appendectomies.

SUMMARY

TWO cases are presented in which acute mechanical intestinal obstruction occurred during the puerperium. In both cases obstruction was due to herniation of the small bowel under a loose adhesion from the appendix stump to the posterior peritoneal wall. A presumptive method of production of this adhesive band has been described.

916 West State Street

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Methyl Testosterone Jaundice

Eighteen cases of jaundice due to methyl testosterone have been reported in the literature and the actual number of cases is probably much greater. In the January issue of the *Annals of Internal Medicine*, Almaden and Ross* report such a case. After prolonged observation they concluded that this condition could not be attributed to any of the usual forms of biliary obstruction or hepatic damage. They believe there is no hepatocellular damage with methyl testosterone therapy.

Liver biopsies show that the lesions are confined to the central zones of the liver lobules and that the bile canaliculi in the central zones are dilated and plugged with bile pigment. There is a moderate amount of bile pigment in some of the liver cells. No inflammatory reaction in the liver lobule or portal is seen, nor

are there any changes in the configuration of the liver lobule itself. The bile ducts are not dilated and contain no bile.


It is the conclusion of these authors and their predecessors, particularly Werner, Hanger and Kitzler, that injury to the liver cells by methyl testosterone leads to disturbance of normal hydration of bile which becomes too viscous to flow through the intra-lobular ducts. There is no reason to believe that methyl groups per se cause this type of jaundice. Hypersensitivity to methyl testosterone has been eliminated as a cause of the phenomenon since jaundice does not return when this hormone is re-administered.

* Almaden, P. J. and Ross, S. W.: Jaundice Due to Methyl Testosterone Therapy. *Ann. Int. Med.* 40:146, January 1954.

GEORGE NELSON[†]
Washington, D. C.

Employing the Physically Handicapped: Labor's Views^{*}

Expansion of rehabilitation services is needed to meet the needs of physically handicapped workers. The enormity of the problem is outlined.

E OF labor are deeply concerned with physical rehabilitation because we know from first-hand experience how acute this problem is today. Besides the individual cases brought to our attention daily, we need only look at the reports of the Bureau of Labor Statistics to find that during the past fourteen years there have been approximately two million industrial accidents. Of this number, about 100,000 workers have been left with total or permanent partial disabilities. Aside from workmen's compensation and public assistance benefits or collections solicited by their fellow workmen, they have little chance of taking their place as useful citizens. The 1952 report of the National Safety Council showed that there were 9,400,000 non-fatal injuries during 1951 and of this number, 9,050,000 were temporary total disabilities; 350,000 were permanent impairments. Countering this, the Office of Vocational Rehabilitation reports that for the year ended June 1951, 66,000 persons had been rehabilitated through its state-federal program. They also estimated that an equal number were rehabilitated through private institutions and voluntary agencies. The Bureau of the Cen-

sus estimates that two million disabled persons in this country could be rehabilitated and placed in employment or in more productive work if programs and facilities were available. The lack of such a program means that, based on the figures of November 1952, we will pay \$395,000,000 annually in public assistance benefits because of disability.

FACED with these sobering facts, let us evaluate what has been done to date and enumerate the unmet needs to change this national situation. A few isolated attempts were made years ago to meet the needs. Most were met with public apathy and even the efforts of the United States Congress in passing the first vocational rehabilitation act some twenty years ago did little to promote a workable program. A real impetus to rehabilitation came from the experiences of World War II. Our manpower needs spotlighted attention on the tremendous waste in our neglect of the handicapped. Advances in physical medicine and selective placement technics made possible the restoration and re-employment of many individuals hitherto considered unemployable. In 1943, Congress again recognized this problem by amending the original act to broaden the federal-state program of rehabilitation. They expanded the

[†] Grand Lodge Representative, International Association of Machinists.

^{*} Presented at the Workshop on Employment of the Physically Handicapped at the Kessler Institute for Rehabilitation, October 2, 1953 (under the sponsorship of the Advisory Committee on Rehabilitation of The Medical Society of New Jersey).

scope of the Office of Vocational Rehabilitation and brought available health services into the program. The War Manpower Commission set up pilot projects in cooperation with industry and labor which proved that, with proper attention, the handicapped could take their place in our production forces on the home front.

With the cessation of hostilities and the return of our disabled veterans, public attention became focussed on the need for rehabilitation and training. Veterans hospitals and private institutes were accomplishing physical rehabilitation and proving that the words "unemployable" and "unfeasible" were just excuses for indifference.

TO ASSIST in this endeavor, representatives from veteran, trade, private and labor organizations prevailed upon the 79th Congress to pass Public Law Number 76, entitled, "National Employ the Physically Handicapped." This law also set aside one week each October for a nation-wide campaign to promote the employment of the handicapped. As a part of this law, the President's Committee on Employment of the Handicapped was authorized. This committee is made up of representatives from organizations in almost every field who endeavor to carry out the objectives of the law through voluntary participation. These objectives have now been expanded to a 52-weeks per year basis and governors' committees are now functioning on state and local levels in a majority of states. At the annual conference of the President's Committee held in Washington in September, many favorable reports were presented from widely-scattered localities. These show that the aims of the Committee are receiving public attention.

Many private associations have been formed which are carrying forward programs of services to the handicapped. Labor unions have also set up rehabilitation services to meet the acute needs of their members. While the majority of these programs are still in the developmental stage, there are some which are in operation. An example is the United Mine Workers Wel-

fare and Retirement Fund. Although this program has been in effect for only two years, almost 9,000 disabled miners have been provided medical rehabilitation services. It is also significant that many of these were severely disabled, including amputees and paraplegics, unfit for any type of employment.

THIS program has already justified our contention that in addition to the human and social aspects, it is just plain good business and common sense to make these people self-sufficient. Typical of the individual cases which have been handled is that reported on in the Public Affairs Pamphlet by Mary Switzer, Director of the Office of Vocational Rehabilitation, and Dr. Howard Rusk, entitled "Doing Something for the Disabled." Referring to an individual case, they said:

Among them was Tom M., a young southern miner, paralyzed from a spinal cord injury twelve years before when a chunk of coal fell on his back. For nine years this man lay in his bed totally helpless, completely dependent upon his family. But he was more fortunate than some, for opportunity came to him three years ago through the program of the United Mine Workers of America Welfare and Retirement Fund. Arrangements were made for him to go to a rehabilitation center on the east coast. There, in six months, Tom was fitted with braces and slowly relearned to walk on his paralyzed legs. Upon his discharge from the rehabilitation center, his state division of vocational rehabilitation arranged for him to enroll in a bookkeeping course. He is now working full time. Tom's change from total dependence to total independence was not a "miracle of modern medicine." It resulted from good planning, the availability of the services he needed, and a determination on Tom's part to "come back." Formerly, a tax-consumer, he is now a proud taxpayer.

ANOTHER illustration of what can be done is the example of the 376 families in West Virginia. In 1951, heads of these families received \$225,000 in public assistance payments because physical disabilities prevented them from earning a living. Through a concerted effort of rehabilitation, they have now been restored to gainful employment and instead of public assistance, they are earning about \$500,000 per year.

Granting that there has been a start made

to erase this national disgrace, then we certainly have the right to ask why the job cannot be completed. Let's take a look at some of the assets we have and the barriers we face.

In the first place, there are thirty-five governmental departments and agencies which today receive appropriations to advance the rehabilitation of the disabled. Workmen's compensation is now on the statute books of every state. The practice of physical medicine has been expanded. Private and voluntary organizations have also been increased. Trained personnel in selected placement and vocational guidance are assisting both our veterans and non-veterans in finding proper employment. The old theory that handicapped workers cannot perform on the job has been refuted.

DESPITE this improvement, it must be admitted that have but scratched the surface. We have only begun to meet the challenge. As I pointed out before, while we are rehabilitating approximately 125,000 per year, this amounts to only about half the people who become disabled each year and we still have a backlog of at least two million people who are in need of rehabilitation and could be employed if they had the chance. What are some of the barriers that stand in their way?

I doubt whether there is a person qualified in this country today who can give the entire answer to this question. In the first place, we have never had an adequate survey of the entire population from which the exact size of this problem can be determined. We do know, from the figures available and partial surveys which have been made, that the greatest single obstacle to a more rapid development of rehabilitation services is the shortage of trained personnel. Particularly is this true in the field of professional personnel including physicians, physical therapists, dentists and nurses. It is reported that there are approximately five thousand qualified physical therapists in practice today. Estimates have been made that there are at least twenty-five thousand positions vacant at present because of lack of personnel. Estimates have also been made that within the next five years we will need ten thousand therapists to fill our needs. In ad-

dition, we are told that there are some thirty-six hundred registered occasional therapists now practicing in hospitals, clinics and rehabilitation centers. Here again, we find some three thousand positions unfilled and double this number will be needed in the next five years. The development of rehabilitation clinics and departments in general hospitals is also urgently needed.

IN answer to questionnaires sent to hospitals throughout the country, we find that of 1600 replying, only 65 had organized rehabilitation services and only 18 allocated specific beds to physical medicine and rehabilitation. We must somehow find a solution to this very real obstacle. There is also a pressing need for more rehabilitation centers, institutions which provide comprehensive services to plan and complete a full program of rehabilitation. This includes the medical, vocational, social and placement functions so vital to assuring adequate rehabilitation, particularly for those in the severely handicapped category. Another definite barrier is our present lack of retraining and vocational opportunities. A start has been made by the Veterans Administration in behalf of rehabilitated servicemen and by a handful of private institutions. Despite the good examples which they have set, the program is all too meager. These examples have proved that when properly applied, we can meet these needs.

From exhaustive studies made by the President's Committee on the Health Needs of the Nation, it is recommended that:

1. An increased number of physicians, dentists, nurses, and paramedical personnel be trained in the special technics of rehabilitation—both through expansion of facilities and through active recruitment of personnel supported by fellowships; and that all health personnel be oriented in the concept of total care of the patient.
2. Development of rehabilitation departments in general hospitals wherever feasible, specialized rehabilitation centers to serve the most difficult cases and to undertake training and research, be encouraged through use of Hill-Burton hospital construction funds and other resources.
3. The federal-state vocational rehabilitation program must be strengthened and expanded through increased federal appropriations and state matching funds.

4. Critical examination be made of present policies in workmen's compensation, disability insurance plans (both governmental and nongovernmental), welfare programs, and employment practices with the intent of strengthening those policies which favor rehabilitation and abandoning those which impede it.

Thus we can see that some of the real barriers are the present lack of facilities, funds and personnel. We must also recognize another serious problem. This problem is the curtailment of appropriations made in the last session of Congress to the Office of Vocational Rehabilitation. Because of this reduction in funds, many of the directors of state programs have already informed us that they will not be able to meet present requirements and must restrict the programs now underway. This is particularly disturbing when we realize that the Office of Vocational Rehabilitation reported that in 1952 some 7,000 less persons received rehabilitation services than in 1951. It is also disturbing because many of the state programs had hoped to start on the large backlog of cases. In addition, it has been commonly agreed that early treatment of the injured or the sick enhances early recovery. Studies have shown that

where the doctor and allied personnel can start early, rehabilitation can be accomplished in a shorter period.

Another very serious consideration in connection with these curtailments is that which affects the employment of the handicapped. Specifically, through the efforts of the President's Committee and the numerous voluntary organizations, emphasis has been placed on the employment of the handicapped. Many employers have indicated their willingness to hire such people. Without proper medical treatment and proper placement, it is likely that we will find many instances where the handicapped are not physically able nor properly trained to fulfill specific job requirements. We of labor are particularly disturbed about this situation. We are convinced that we must have an expanded program of federal-state cooperation and coordination in order to realize any appreciable gains.

If we are serious in our efforts to wipe out this national problem, it will take all-out teamwork between our federal government, the medical profession, placement specialists, our educational system, labor, management and the general public. There is no reason why such teamwork cannot be achieved.

9th Street and Mt. Vernon Place, N. W.

Histoplasmosis

Histoplasmosis, formerly considered a rare disease, has now been found to be fairly common in the midwest. The endemic centers of histoplasmosis occur where there is a high incidence of pulmonary calcifications and histoplasmin skin reactors.

Prior,* *et al.* have recently reviewed the characteristics of histoplasmosis.

Protean manifestations occur in this disease. Patients may have irregular fever, weight loss, anorexia, vomiting, diarrhea, jaundice,

cough, or hepatomegaly. In the more severe cases leukopenia and anemia occur. The course varies from a mild vague illness to a very fulminating, rapidly fatal disease.

The diagnosis is established by a positive histoplasmin skin test, serologic tests, and the isolation of *H. capsulatum*. Biopsy of affected lymph nodes, mucocutaneous ulcers and bronchoscopic specimens are also of value.

No satisfactory treatment has yet been found. All of the sulfonamides and antibiotics are ineffective and experimental studies suggest that streptomycin may aggravate the disease. The present treatment remains largely supportive and nonspecific.

* Prior, J. A., Saslaw, S. and Cole, C. R.: Experiences with Histoplasmosis. *Ann. Int. Med.* 40:221, February 1954.

H. C. GOLDBERG, M.D.

Plainfield

WILLIAM SNYDER, M.D.

Paterson

Ringworm of the Scalp

After describing the different forms of scalp fungus infections and types of treatment available, x-ray epilation is advised as the most efficacious.

TINEA capitis continues to be a therapeutic challenge to the physician. Our purpose is to discuss and appraise current methods of diagnosis and therapy.

Most cases of scalp ringworm are due to *Microsporon audouini* or *M. canis*. A Wood's light is indispensable in routine detection of such infections. This light consists of an ultraviolet source filtered through glass containing sodium borate silicate and nickel oxide, transmitting radiations of 3600 Angstroms. Under it, hair stubs infected with *M. audouini* or *M. canis* present a characteristic greenish fluorescence. This is a very pale green, which, when once seen is unforgettable. Many fluorescent substances are seen on the scalp but are easily distinguished from the fluorescence of the infected hairs.

Errors in diagnosis can be made by not removing all ointments from the head prior to examination. Infected hairs should be cultured as an aid in establishing the causative fungus and deciding on the treatment. Lack of fluorescence does not rule out the possibility of infection with *M. gypseum* or the *Trichophyton* group of dermatophytes.

An increasing number of tinea capitis cases due to *Trichophyton tonsurans* is being seen in the United States. Originating in Mexico, such cases have spread to California and Texas and

have been reported in Indiana, Ohio, Pennsylvania, and New York, often in recently immigrated Puerto Ricans.¹ Diagnosis of this type tinea is difficult, for there is no fluorescence in dark haired patients and the scalp may simulate folliculitis, recurrent furunculosis or lupus erythematosus.² This organism infects both adults and children. The *Microsporon* group is rarely found in adults, probably due to the greater quantity of adult scalp sebum, containing fungistatic fatty acids.³ Treatment of these non-fluorescent cases is much more difficult than those due to *M. audouini* or *M. canis*. X-ray epilation plus thorough manual epilation of all hair stubs is necessary as the response to local medication alone is poor.

WHEREAS the cases due to *M. Canis* are contracted usually from household pets, those due to *M. audouini* are transmitted by direct contact among children, indirect contact through theater seats and unsterile barber shop technics. Transmission of several cases was traced by one of us (H.C.G.) to a hat store where the proprietor fitted hats on children with scalp ringworm. Since the disease is not disabling, the health department in one large city allocates little time and funds for case finding. However, we believe that children in contact or in the same class-room with a

proved case should be screened. This can be done easily and rapidly with a Wood's light. For the affected child the disease assumes great importance for he may be excluded from some public schools. Some schools permit attendance if the child is under treatment and wears a stocking cap at all times. We feel exclusion from school is best, especially since it affords an opportunity to expedite treatment. Where the child is permitted to attend school, parents are often content to let the disease process drag on.

Although *M. canis* characteristically produces a more inflammatory reaction than *M. audouini*, the latter can also occasionally produce inflammation of the scalp and even carbuncle-like kerions. Management of such acute inflammations with antiseptic wet compresses and antibiotics must take precedence over specific fungicidal therapy. *M. canis* infections are cured readily with most fungicides, though probably this is due to the fact that it usually runs a short self-limited course of three to six months. Of the many fungicidal preparations available, in our experience none have good curative powers in *M. audouini* infections. In clinical trials of fungicides by one of us (W.S.), the most efficient preparation produced cures in only 25 per cent of cases.⁴ Evaluation of such preparations is difficult because of occasional spontaneous cures in some cases after many months.⁵

MANY proprietary preparations are available. One large institution, after considerable experimentation, has gone back to the familiar 5 per cent ammoniated mercury ointment which we feel is as useful as any preparation available and is inexpensive. The organism invades the entire hair down to the hair bulb or papilla, which is one-fourth of an inch under the scalp. This anatomic fact accounts for the ineffectiveness of most medications even though some are formulated to produce some penetration of the hair shaft lying beneath the skin. The ammoniated mercury ointment is applied once daily after washing the scalp. The hair should be cut as close to the scalp as possible to make the application of

medication and washing as simple as possible. A stocking cap is worn at all times and this is to be boiled and changed daily.

Estrogen therapy at one time was hopefully tried, based on the fact that at puberty most of these patients spontaneously get well and few cases occur after puberty. Unfortunately, a thorough trial of hormonal drugs has proved them to be of no help in this problem.

Epilation of the scalp is the quickest and surest method of curing these scalp infections. Manual epilation of infected hairs is helpful but tedious. Thallium acetate administered orally produces epilation, and, although advocated in a recent text,⁶ is rarely used in the United States due to its inherent toxicity. In other countries it is used in a limited way. Recently, it was accidentally discovered that some topical fungicides produced a toxic alopecia, and work is now in progress to apply this side effect to therapeutic use.⁷ One must rely on superficial x-ray therapy to achieve a complete temporary epilation.

THE Adamson-Keinbock technic of scalp exposure was devised in 1909 and has stood the test of time. This procedure has been followed by us over a period of many years. When used with an adequate amount of radiation, all the hairs on the scalp begin to loosen about 18 days after x-ray treatment has been given. Many of the hairs fall out spontaneously. The rest are removed easily and without pain by applying adhesive tape to the scalp for a few minutes and then removing it. The ringworm condition is thereby cured, since the organism lives on the hair which has been entirely removed.

After this hair fall, usually four to six weeks after the single x-ray treatment has been given, the child is ready to go back to school. At this time he is no longer a public health hazard to his neighbors' children nor to his schoolmates. About six to eight weeks after he returns to school his scalp hair begins to regrow.

In the past 12 months we have epilated twenty patients ranging in age from two to eleven years. Some of these had been under active treatment with other methods for as

long as two years prior to the x-ray epilation treatment. Of these 20 cases, only one failed to improve in the usual period of four to six weeks.

No other method compares with x-ray epilation in efficiency, in certainty, in helping to

return the child to a normal existence, in relieving anguished parents, in easing clinic patient load and in relieving social service workers for other tasks. Today this is not only the method of choice, but is the only good method of treatment.

7 Watchung Avenue, Plainfield
555 Broadway, Paterson

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Failure of Exchange Resins

Cation exchange resins have not fulfilled early expectations. Those in clinical use do not retain a significant amount of sodium in the feces when the patient is on a sodium restricted diet.

In an effort to explain this disappointing result, Field,* *et al.* have studied the fate of sodium in the colon when it is exposed to cation exchange resins.

Their experimental studies show that the colon has sufficient power to absorb sodium so as to overbalance the affinity of the resin for this cation. The colon has a role in the conservation of sodium which may be comparable to that of the kidney. It gives up large amounts of potassium to the resin. Neither the colon nor the kidneys are effective conservers of potassium.

From these experiments it can be seen that the use of cation exchange resins to control the sodium metabolism of the body is limited because when patients are already on a sodium-free diet the colon will take up any sodium absorbed on the resin and return it to the general circulation. On the other hand, the colon will give up potassium in exchange for this sodium. The overall result of this chemical function of the large bowel is to negate the sodium eliminating features of the resin and to add to those factors which may produce a state of hypokalemia.

* Field, H., Swell, L., Flick, D. F. and Dailey, R. E.: Cation Uptake by Exchange Resin in Vitro and the Colon as a Sodium Conserving Organ. Circ. 9:32, January 1954.

Announcements • • •

Radiation Therapy Meeting

The radiation therapy alumni association of Bellevue Hospital announces a meeting to be held on Thursday, May 20, at 2:30 p.m.

The annual Ira I. Kaplan lecture will be given by Dr. I. T. Nathanson who will discuss hormonal therapy in cancer of the breast.

The meeting will be held at the main lecture hall of the New York University-College of Medicine, 477 First Avenue, New York City.

Scout Camp Doctor Wanted

The Eagle Rock Council of the Boy Scouts of America is anxious to obtain the services of a physician, nurse or medical student for its summer camp. Applicants should write directly to the Eagle Rock Council, Boy Scouts of America, 60 South Fullerton Avenue, Montclair, or telephone Montclair 2-4424.

N. J. Neuro-Psychiatric Institute Admissions

The New Jersey Neuro-Psychiatric Institute is functioning as a diagnostic treatment training and research center for various psychiatric and neurologic disorders.

A department of research has been established and an intensive training program undertaken.

The patients eligible for admission are those with epilepsy who do not have a complicating psychosis or mental deficiency, juvenile psychotics, alcoholics, patients with neurologic disorders such as multiple sclerosis, amyotrophic lateral sclerosis and cerebral palsy, drug addicts and sex offenders.

Health Education Conference

The 1954 Eastern States Health Education Conference will be held at the New York Academy of Medicine on April 29-30. The subject of this year's conference will be communication in health education.

Further information may be obtained by writing to Iago Galdston, M.D., 2 East 103 Street, New York 29, N. Y.

Public Health Scholarships

The Harvard School of Public Health will grant postgraduate scholarships in amounts up to \$5,000 to candidates during the academic year 1954-55.

Physicians interested in preventive medicine and who desire training leading to either a Master of Public Health or Doctor of Public Health degree, and industrial physicians are among those eligible to apply.

Scholarship applications must be submitted by April 30 and may be obtained from the Secretary, Harvard School of Public Health, 55 Shattuck St., Boston 15, Mass.

ACCP Luncheon

The New Jersey Chapter of the American College of Chest Physicians will hold its annual luncheon meeting on Wednesday, May 19, at 12:30 p.m. in the Carolina Room of Chalfonte-Haddon Hall, Atlantic City.

Dr. Burgess Gordon, President of the Women's Medical College, Philadelphia, will be the guest speaker.

Meeting on Mental Deficiency

The American Association on Mental Deficiency will hold its 78th annual meeting at the Marlborough-Blenheim Hotel in Atlantic City, May 18-22.

An extensive program has been outlined with a number of special sessions devoted to medicine and psychiatry.

The complete program may be obtained from Dr. L. N. Yepsen, Executive Vice-President, American Association on Mental Deficiency, New Lisbon, N. J.

Pan-Pacific Surgical Congress

Honolulu will be the host city for the sixth Pan-Pacific Surgical Congress, which will meet October 7-18. Further details may be obtained from F. J. Pinkerton, M.D., Suite 7, Young Hotel Building, Honolulu, Hawaii.

International College of Surgeons

The Northeastern Division of the United States Section of the ICS will hold a meeting in Poughkeepsie, N. Y., May 27-28. Speakers will include Drs. Max Thorek and Arnold S. Jackson.

The Ninth Biennial Congress of the ICS will meet in Sao Paulo, Brazil, April 26 to May 2. Details of the program may be obtained by writing directly to the headquarters of the College at 1518 Lake Shore Drive, Chicago 10, Ill.

International Congress of Internal Medicine

The third International Congress of Internal Medicine will be held in Stockholm on September 15 to 18. The program features symposia on hypertension and collagen diseases, as well as discussions of heart disease, endocrinology and other topics of interest to internists.

Interested physicians are advised to contact the American-Swedish News Exchange, Inc., 630 Fifth Avenue, New York 20, N. Y.

County Society Reports • • •

Atlantic

A regular meeting of the *Medical Society of Atlantic County* was held at the Traymore Hotel, February 12, Dr. E. Harrison Nickman presiding.

The society was honored in having for its guests the representatives from the health and welfare agencies and institutions of Atlantic County.

The following were elected to membership: regular in transfer from Montgomery County, Pennsylvania, Dr. Amedeo A. Barbanti; Dr. Albert J. Battaglia, in transfer from Gloucester County; and Dr. Joseph I. Esposito; associate: Dr. Irving E. Braverman.

The society voted to participate in a centennial edition of the *Atlantic City Press* on February 28.

LEONARD B. ERBER, M.D.

Reporter

Dr. Harold K. Eynon presented several questions raised by the Medical-Surgical Plan regarding payment of surgical assistant's fees. After some debate the Society unanimously concurred in a negative note to all questions. It was reiterated that the custom of this county has always been for the surgeon to receive the full and only fee for a surgical procedure.

Spirited discussion was evoked before a vote was taken on the issues concerning the relationships between osteopathy and medicine. A sizeable majority supported the recommendation for doctors of medicine to teach in osteopathic schools. An affirmative vote by a wide margin was likewise declared in favor of state associations studying the relationships between osteopaths and doctors of medicine.

FREDERICK W. DURHAM, M.D.

Reporter

Camden

The regular monthly meeting of the *Camden County Medical Society* was opened by Dr. Edwin R. Ristine, president, on March 2 at the Camden City Dispensary Building. Dr. Henry B. Decker introduced the guest speaker, Dr. Leandro M. Tocantins, hematologist, who presented a paper entitled "Chemotherapy of Malignant Disease of the Hematopoietic Organs."

Dr. Philip D. Gilbert offered a memoir on the passing of Dr. Maurice E. Baker.

The membership was again reminded of the need for their hearty cooperation at the Public Health Forum on April 23-25.

Cumberland

Under the chairmanship of Dr. Kurt M. Hansen, its president, the *Cumberland County Medical Society* held a regular meeting at the Cumberland Hotel, Bridgeton, on February 9.

The speaker was Dr. Bernard J. Ronis, Associate Professor of Otolaryngology, Temple University School of Medicine. Dr. Ronis spoke on modern advances in otology.

The following were elected to full membership: Drs. Murray D. Fenichel, Frederick D. Snyder, and William S. Flithin.

GEORGE F. RISI, M.D.

Reporter

Gloucester

Dr. Ralph L. Moore presided at the regular monthly meeting of the *Gloucester County Medical Society*, held at the Woodbury Country Club, January 21.

Dr. J. Woodrow Savacool, associate in medicine at the Jefferson Medical College, was the speaker for the scientific program. His subject, "The Treatment of Chronic Pulmonary Diseases from the Standpoint of the General Practitioner" was ably covered. Dr. Savacool also answered many questions propounded by the interested audience.

A letter was read from the Red Cross thanking the physicians for their cooperation in the work of the Bloodmobile, but requesting that the doctors help to sell the idea of giving blood for their patients.

After discussion of the fee splitting problem, which does not seem to exist in this area, a motion was passed that the society favors the payment of separate fees by Blue Shield to both the surgeon and his legitimate assistant.

An informal vote indicated that more members would attend a convention cruise than the annual meeting in Atlantic City.

LOUIS K. COLLINS, M.D.

Reporter

Mercer

Under the chairmanship of Dr. Ernest F. Purcell, Sr., its president, the *Mercer County Medical Society* held a regular meeting on February 10 at the headquarters of The Medical Society of New Jersey.

The guest speaker was Dr. Henry J. Tumen, Associate Professor of Medicine, Graduate School of Medicine, University of Pennsylvania, whose subject was "The Differential Diagnosis of Jaundice."

Dr. Arthur Sacks-Wilner, Chairman of the Public Relations Committee, reported that the second series of the radio program "Help Yourself to Health," sponsored by the Mercer County Medical Society and its Auxiliary, had been launched February 1. This is a community service program presented to the public through the facilities of station WBUD with the cooperation of Mrs. Nan Rednor, known to radio listeners as "Nan About Town." It consists of panel discussions dealing with public health. The program will continue for thirteen weeks, and is on the air every Monday evening at 7 o'clock.

The following were elected to membership; active: Dr. Jerome H. Greenberg, Trenton, and Dr. Aaron J. Heisen, Imlaystown, in transfer from Monmouth County Medical Society; associate: Drs. James F. Fitzpatrick and Joseph McCarthy, Trenton.

JOHN A. KINCZEL, M.D.

Reporter

Middlesex

Dr. Malcolm M. Dunham presided at the regular monthly meeting of the *Middlesex County Medical Society* held at the Roosevelt Hospital, Metuchen, on February 17.

The following were elected to regular membership: Drs. Le Roy Homer, Woodbridge, by transfer from the Philadelphia County Medical Society and Gerald J. Aitken, now in Japan with the U. S. armed forces, from associate membership.

An interesting paper on the interpretation of pain as a gynecologic symptom was presented by Dr. A. Herbert Marbach, Senior Attending Gynecologist and Obstetrician, Albert Einstein Medical Center, Northern Division.

At the meeting of the Special Committee on Division of Surgical Fees by the Medical-Surgical Plan of New Jersey, held on December 6, 1953, the group formulated the following questions for consideration by the county medical societies:

1. Do you approve adequate remuneration of an assistant for his part in a surgical case?
2. Do you think it would be ethical to do so?
3. Do you think the Medical-Surgical Plan should pay the fee for assistant services?
4. Do you think that the proposed payment of fees is a forward step on the part of the Society in combatting fee-splitting as it exists today?
5. Should the assistant's fee be deducted from the surgical fee?

The questions were voted upon and the answers were yes for questions one, two, three and four and no for question 5.

IVAN B. SMITH, M.D.

Reporter

Monmouth

George Sheehan, Jr., program chairman, opened the scientific session of the regular monthly meeting of the society, held at the Borden Pavillion Auditorium, Monmouth Memorial Hospital on February 24, by introducing the participants of the panel discussion on heart surgery. The members of the panel were: Dr. Daniel Downing, consulting pediatric cardiologist of the Bailey Clinic, Hahnemann Hospital; Dr. Jere Lord, associate professor of clinical surgery at New York University School of Medicine; and Dr. J. J. Smith, medical director of Jersey City Medical Center.

Following this symposium the business session was convened by the president, Dr. George McDonnell, at which time the annual elections were held. The newly-elected officers, to be installed in June, are Dr. Howard C. Pieper, president; Dr. William F. Jamison, president-elect; Dr. Lester A. Barnett, secretary-treasurer; Dr. Morton F. Trippe, assistant-secretary-treasurer and Dr. Donald W. Bowne, reporter.

MORTON F. TRIPPE, M.D.

Reporter

Morris

An interesting panel discussion featured the regular meeting of the *Morris County Medical Society* on February 18, held at the Warner-Hudnut Auditorium in Morris Plains.

Dr. Nicholas Bertha, vice president, occupied the chair in the absence of the president.

The panel discussion was on compensation and the members of the panel were Mr. William H. Walker (N. J. Manufacturers Casualty Company), Mr. Lester A. Skinner (Liberty Mutual Insurance Company), Mr. William A. Stevens (Hartford Accident & Indemnity Company). They spoke respectively on physicians' fees in compensation cases, physicians' reports and the basis of insurance carriers' cost calculations.

In addition, Judge G. Robert Winfield, Deputy Director of the New Jersey Department of Labor and Industry addressed the group on the choice of physicians in compensation cases.

ALBERT ABRAHAM, M.D.
Reporter

Somerset

With Dr. Alan J. Stelow presiding, a regular business meeting of the *Somerset County Medical Society* was held on February 11 at the nurses'

home of the Somerset Hospital. Mr. Howard Dayton of the Heart Association addressed the group concerning the functions and aims of the national, state, and local heart associations. A committee composed of Drs. George A. Greenberg, Marcus E. Sanford and Robert W. Wilson was appointed to make arrangements for an organization meeting; the members present unanimously adopted a motion that the society participate in and sponsor such a local association.

The society approved the establishment of a mental health clinic for Somerset County.

Dr. William E. Boutelle was elected to full membership in the society.

C. SCOTT McKINLEY, M.D.
Reporter

New Jersey Rheumatism Association

An Academy Stated Meeting under the auspices of the *New Jersey Rheumatism Association*, was held at the Newark Academy on February 18.

The speakers of the evening were Dr. Clarence B. Whims, who spoke on useful gadgets in the management of arthritis; Dr. Peter J. Warter, who discussed combined treatment of rheumatoid arthritis with Solganol® and cortisone, and Dr. E. Vernon Davis, who spoke on the role of trauma in arthritis.

CYRIL M. CANRIGHT, M.D.
Reporter

Obituaries • • •

DR. RICHARD D. ANDERSON

Dr. Richard D. Anderson, 60, died at his home in Burlington on February 6.

Dr. Anderson was a graduate of the University of Virginia Medical School, class of 1917, and a member of the American College of Physicians. He also belonged to the Calcanon Medical Fraternity.

Dr. Anderson was a member of the Board of Managers of the Marcus W. Newcomb Hospital for Chest Diseases. During both world wars he served as a naval commander.

DR. JOHN J. HIRSCH

Dr. John J. Hirsch of Wallington died on February 9 at the age of 46.

Dr. Hirsch was graduated from Zurich Medical School in 1938. Following his internship and residency at the Jersey City Medical Center he began his practice in Wallington in 1940.

During World War 2 Dr. Hirsch served as a captain in the Army Medical Corps, and following the war, as director and vice-president of Hillel Academy, Passaic.

Executive Board Meeting

On March 8 a regular meeting was held at the Executive Offices in Trenton. The meeting was called to order by Mrs. Frank Forte, President.

Reports were read by the state chairmen and county presidents. Delegates were appointed to attend the national convention which will be held in San Francisco, June 21-25.

The Annual Public Relations Conference will be held at State Society Headquarters on April 28. Mrs. Anton Randazzo, Public Re-

lations Chairman for the Auxiliary, announced that the conference theme is "Mutual Cooperation and Medical Care." It is the aim of the program to bring home to all members of the medical profession and to the general public the realization that good medical care can only be enjoyed when, in a spirit of mutual respect and responsibility, all who are part of it work together.

MRS. JOHN J. MUCCIA,
Chairman, Press and Publicity

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

The Mechanisms of Disease. By Joseph Stambul, M.D. Pp. 746. New York, Froben Press, Inc., 1952. (\$15.00)

Dr. Stambul undoubtedly expended a great amount of time and energy in compiling the data for this book. Unfortunately, the end result is disappointing. Except as an extensive and detailed review of biochemical and physiologic literature for the past fifty or seventy-five years, this book has little to offer the reader. The greater part of each chapter is devoted to a review of the relevant scientific literature. Had the author stopped there, and presented his work as a comprehensive review rather than attempting to present new theories, he would have succeeded. His conclusions, based on specious reasoning and physiologic syllogisms, are the questionable aspects of the book.

In the author's general introduction he states, "The study of the mechanisms of disease has been very largely neglected." This is not true. There is a wealth of material and continuing research on the pathogenesis of almost every disease known to mankind. The author's thesis is that the cells of the body, or rather the cell membranes, are controlled by the autonomic nervous system and by

hormones. He states, "The hormone of the pancreas, insulin, influences the deposition of glucose in the muscle cells by counteracting the membrane semipermeability and permitting the glucose from the surroundings to enter the cells." Thus, with one simple stroke, he clears up the mystery of the action of insulin and bypasses the work of Krebs, the Coris, and all the other great investigators who are still trying to determine precisely how insulin acts.

He makes such dogmatic statements as: "The favorable therapeutic effects of cortisone and ACTH on various diseases are due to the decrease of permeability of the diseased tissue cells, enhancing the recovery of their normal chemical composition." There he offers a simple answer to a complex problem which has not yet been solved by thousands of researchers in the field of adrenal physiology. A little later he states "Such bodily changes are . . . the result of the drug (epinephrin), which may be counteracted or reversed by the administration of therapeutic agents which decrease membrane permeability, such as cortin and cortisone." The use of cortisone as an antidote for epinephrin will indeed be a novelty to most physicians.

The forty-three chapters of this book purport to

explain the mechanism of virtually every well-known medical disorder. Each chapter starts with a lengthy review of the literature. This portion of each chapter is comprehensive but its value is impaired by that small end piece entitled "Summary and Practical Considerations," which over-simplifies the problems involved. Dr. Stambul goes particularly far afield when he considers the adrenal cortex because he repeatedly refers only to the "adrenal cortical hormone" and does not recognize that this is not a single entity but a combination of three separate physiologically active substances.

Psychiatrists will be shaken to find that their treatment of schizophrenia has been along the wrong track for these past many years. Dr. Stambul states as follows: "If it is accepted that the treatment of schizophrenia is directed toward stimulating the sympathetic nervous system to greater activity, it can be accomplished by simpler and safer methods than by convulsive therapy which frequently causes serious complications."

These few examples illustrate the weakness of this book. It is well printed and nicely bound. The unsophisticated reader is advised to learn about the pathogenesis of disease from standard textbooks of pathology, physiology, biochemistry and medicine rather than to rely on the novel exposition propounded here.

R. D. GOODMAN, M.D.

Understanding the Japanese Mind. By James C. Moloney, M.D. Pp. 252. New York, The Philosophical Library, 1954. (\$3.50)

Some Japanese psychiatrists, considering themselves analysts, still use moxa therapy, which consists in the burning of certain leaves on the patient's skin. It is an old and "classical" Japanese technic. But to many Japanese psychiatrists, it is perfectly compatible with modern psychotherapy, even with psychoanalysis.

The basic Japanese concept is that Japan, as such, is the only true entity. Individuals exist, as parts of this entity, only to serve this mother-nation. The entire life of a Japanese is, as Dr. Moloney puts it "governed by the id, and directed toward a return to the womb . . . The Japanese analyst tries to tighten the patient's 'inner thongs,' to force him backward into the status of primitive mankind where animism reigns. The goals of western psychoanalysis are growth, maturation and expansiveness; of Japanese psychoanalysis, the opposite."

So Japan takes western psychoanalysis and uses it towards its own goals. While malaria and fractured legs may be the same on the Japanese islands as on Manhattan or in the isles of Greece, this is not true of emotional illness. "Japanese males" says Dr. Moloney, "even when insane, conform to authority."

This book is a tightly reasoned, but leisurely paced interpretation of the Japanese mind by a skilled psychiatrist who knows how to write interestingly. It is filled with odd observations, quotable anec-

dotes and thought-provoking hypotheses. It can provide fodder for hours of discussion, and should hold a psychiatric journal club in session for a week.

HERBERT BOEHM, M.D.

Peptic Ulcer. By Lucian A. Smith, Assistant Professor of Medicine, Mayo Foundation, and Andrew B. Rivers, M.D., Late Associate Professor of Medicine, Mayo Foundation. Pp. 576. New York, Appleton-Century-Crofts, Inc., 1953. (\$10.00)

This book is the third of the same title in the last three years to be published. Perforce, it contains an element of repetition, since the other two were equally well done.

This compilation, like the others, follows prescribed patterns which do not detract from its importance. One whole chapter is devoted to a history of the men who have studied this disease surgically and medically and whose efforts were directed to achieving some measure of a cure.

Considerable attention is paid to the anatomic and physiologic aspects of abdominal pain culminating in an integration of the syndrome peptic ulcer. Too much stress cannot be laid upon this exhaustive study.

Then follow the patterns which have been utilized in the past, chapters on esophageal, gastric and duodenal ulcers. There are also discussions of the complicated ulcer. Considerable satisfaction was felt in the attention given that complication of complications, intractability.

ANDREW J. V. KLEIN, M.D.

Breaking Patterns of Defeat. By Richard L. Jenkins, M.D. Pp. 271. Philadelphia, J. B. Lippincott Company, 1954. (\$6.75)

The concept of emotional illness as a pattern of defeat is not, perhaps, brand new, but it has never before been presented in so arresting a fashion. Dr. Jenkins painstakingly, yet simply, traces the ways in which people react to threats, and suggests why they react in these different ways. He then points up the many instruments in the orchestra of mental health which can, if the baton wielder is skillful enough, provide harmony. The psychiatrist, school teacher, nurse and psychologist, the social worker and the clergyman, all who work with emotionally disturbed people will find here a gold mine of shrewd observation and usable advice about the mechanism of self defeat.

There are several refreshing chapters on technics in psychotherapy. The book is written with modesty, deft humor, and a kind of common sense which gives it an intellectual flavor. It is of interest to all who are professionally or personally concerned with people who have been defeated by life, or who act as if they have.

HENRY A. DAVIDSON, M.D.

Supplied by New Jersey Trudeau Society

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

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No. 4

The Role of Antibiotic Drugs in the Treatment of Tuberculosis

By Frederick Beck, M.D., *New York State Journal of Medicine*, October 15, 1953.

In the past five years the treatment of tuberculosis has changed as a result of the rapid development and application of antimicrobial therapy and thoracic surgery. Concomitantly, one would suspect that the treatment of tuberculosis should become simple but actually it is more complex because many more patients are suitable for surgery which requires (1) selection of drugs, (2) determination of the type and timing of surgery, and (3) consideration of duration of postoperative drug therapy.

The development of tuberculosis antimicrobial therapy has been rapid beginning in 1947 with the introduction of streptomycin which was soon followed by para-aminosalicylic acid, the thiosemicarbazones, and in late 1951 by the nicotinic acid derivatives. These drugs in various combinations have become very popular. In reviewing the patients with active disease at Ray Brook State Tuberculosis Hospital (N. Y.) these drugs are currently being used on 50 to 60 per cent of the patients, and practically all the remainder have been treated with drugs at some time. There is an increasing trend toward immediate chemotherapy or antibiotic therapy of tuberculosis patients upon diagnosis and, in fact, even upon mere suspicion of the disease.

The treatment of non-tuberculous disease as tuberculosis is not rare, and the importance of the bacteriologic diagnosis before initiating such treatment should be stressed. There are occasional instances where after prolonged study for several

weeks bacteriologic proof is lacking. However, in these cases the possibility of non-tuberculous infectious disease such as broncho-pneumonia, virus pneumonitis, or fungus disease should be carefully evaluated. It is important to secure information concerning the *in vitro* sensitivity of the patient's organisms at the start of treatment. By this is meant a determination of the effect of varying concentrations of streptomycin, para-aminosalicylic acid and isoniazid on the bacilli to establish whether there is a drug effect and at what level. Knowledge of the sensitivity enables one to favor those drugs demonstrated to be effective by the *in vitro* tests.

Today drugs are used in combination. It was found quite early that when streptomycin was used alone, resistant organisms might be recovered several weeks after start of treatment and were in the majority after 60 days. The addition of PAS delayed and reduced the incidence of resistance.

At present the best combination, from a therapeutic, bacteriologic, and radiologic standpoint is streptomycin and PAS. In 1951 and 1952 a comparative study of streptomycin and dihydrostreptomycin in the New York State tuberculosis hospitals showed that there was no difference in therapeutic efficacy at 120 days of treatment and no significant difference in emergence of drug resistance. Vestibular disturbances are more frequent, of greater severity, and often occur earlier when streptomycin is used while auditory disturbances are more frequent with dihydrostreptomycin and may progress after treatment is stopped or may appear after conclusion of treatment.

With regard to dosage, a group of patients in the Ray Brook Hospital recently studied has been alternated between 1 gm. daily of streptomycin and 1 gm. of streptomycin three times a week. In addition to the streptomycin, they received 12 gm. of PAS daily. At an evaluation after 120 days we were unable to recognize any significant difference between the two groups from a clinical, therapeutic, x-ray, or bacteriologic standpoint and have tentatively reached the point where we believe that 1 gm. of streptomycin given three-times-a-week is as effective as the same amount daily and is more convenient and potentially less toxic for longer periods of treatment.

Isoniazid has been used by us since early 1952. The original studies were done in cooperation with several other sanatoria in the Saranac Lake area. The first cases treated were, for the most part, far advanced with organisms resistant to streptomycin, and iso- and iproniazid were used in alternate cases. Practically all of these cases developed resistance to the drug rapidly, and it was decided to test the drug in combination with streptomycin or PAS. The clinical progress of patients on both of these combinations is quite satisfactory. Data which will indicate whether isoniazid is as effective as PAS in postponing streptomycin resistance are now being sought. If it is, isoniazid would seem to be a more satisfactory drug to use in combination with streptomycin than PAS, which often causes allergic manifestations. On the other hand, in view of the fact that there are more strains of tubercle bacilli naturally resistant to INH, this combination may not be as effective in regard to the development of INH resistance.

When one considers optimum duration of therapy, we must take into account our concepts of the treatment of the disease and our objectives.

The past decade has been marked by a better understanding of the potential hazard of residual disease foci and by the demonstration of the practicability of surgical removal of lobes, segments, or smaller areas of diseased lung tissue.

Some patients are not suitable candidates for surgery because of such factors as extent and distribution of disease, age, or general condition. The trend in this group has been toward longer courses of antibiotics.

In the bacteriologic study of resected lung specimens, it has been repeatedly demonstrated that acid-fast bacilli can be found microscopically in many specimens, but cannot be grown by culture, nor will they produce disease in guinea pigs. The same situation can occur in old, encapsulated or arrested lesions. It would be desirable to determine whether it is truly possible to kill all the tubercle bacilli in the host with longer terms of therapy or whether these bacilli are only in a dormant phase.

Hospital care is necessary at some period for every patient with active tuberculosis. The problem is much broader than that of medical treatment alone. If the patient has a positive sputum, he is a source of infection to others, and he should be in a hospital. Home care is an important adjunct to hospital care but must be organized with an adequate staff and carefully coordinated in order to achieve the maximum medical and rehabilitation benefits. In answer to the common belief that patients will be more content at home, I shall only say that I am convinced that patients can become content in a tuberculosis hospital if the hospital standards are high and if proper attention is given to the interpersonal relationships of the hospital personnel and the patients.

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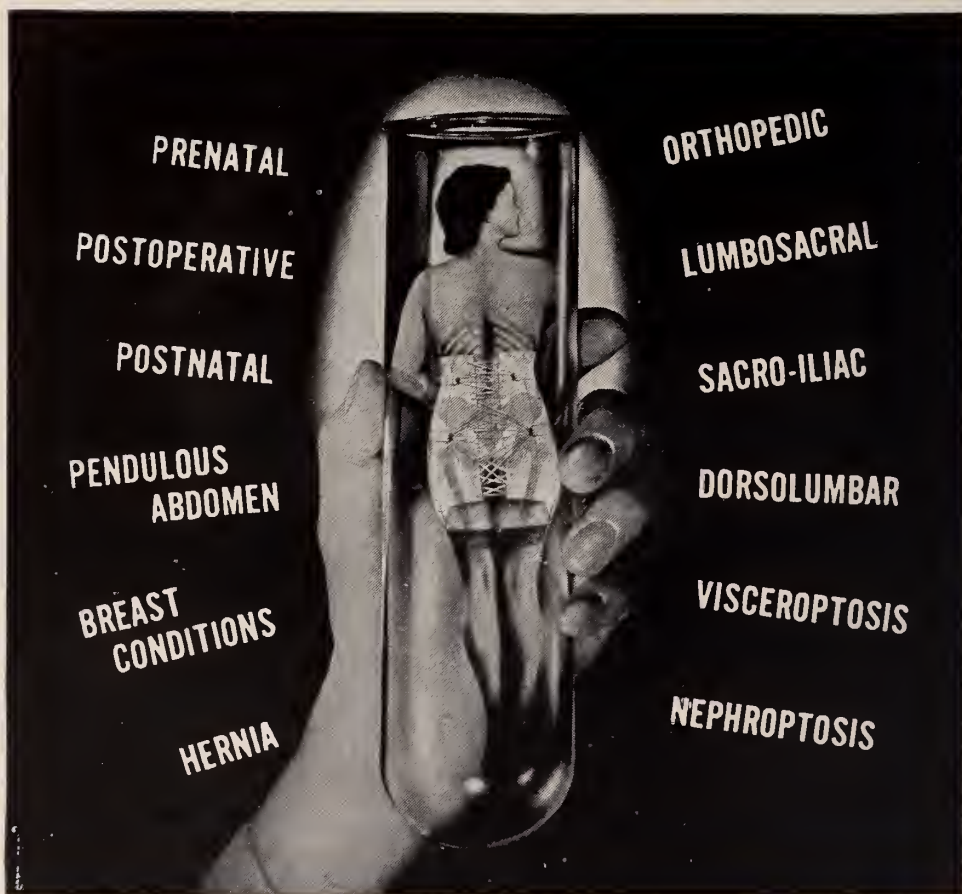
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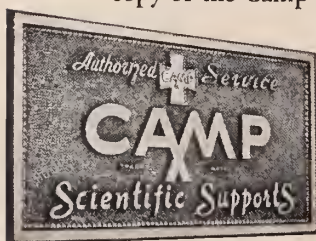
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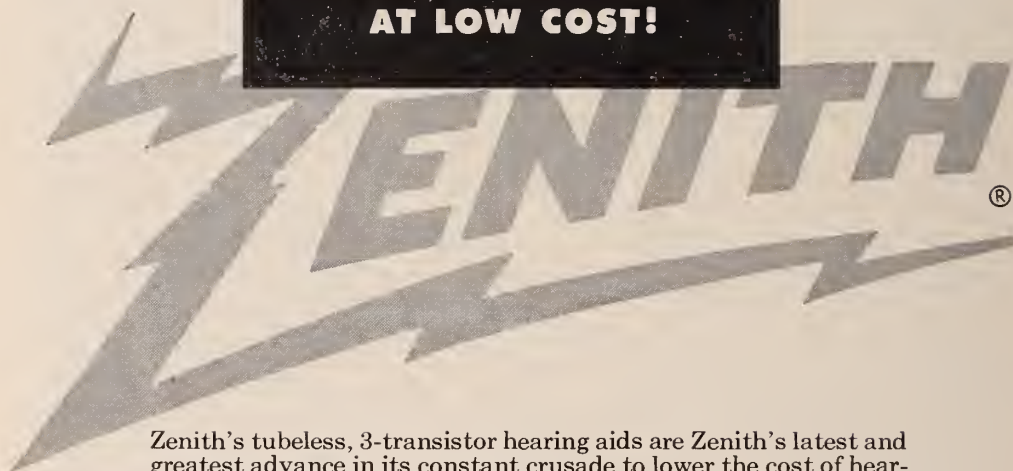
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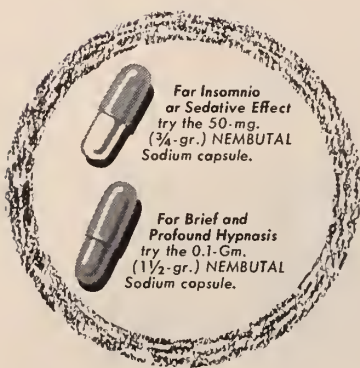
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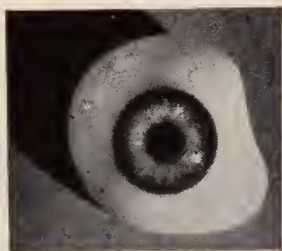
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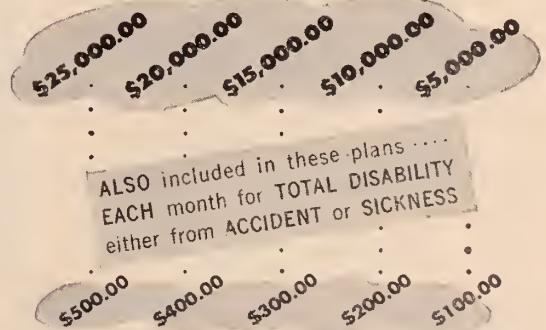
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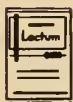
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THE JOURNAL

OF

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Accident and Health Insurance

The MEDICAL SOCIETY OF NEW JERSEY has officially selected the plan of our Company for Accident and Health Insurance and the policy is available to Society members in accordance with the Company's rules and regulations for acceptance of risks.

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EXECUTIVE AND EDITORIAL OFFICES, 315 WEST STATE ST., TRENTON 8, N. J. Tel. Trenton 4-3154

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Estrogenic substances (water-soluble), also known as conjugated estrogens (equine). Available in both tablet and liquid form.

1. Werner, A.: Acta endocrinol. 13:87, 1953.

2. Malleson, J.: Lancet 2:158 (July 25) 1953.

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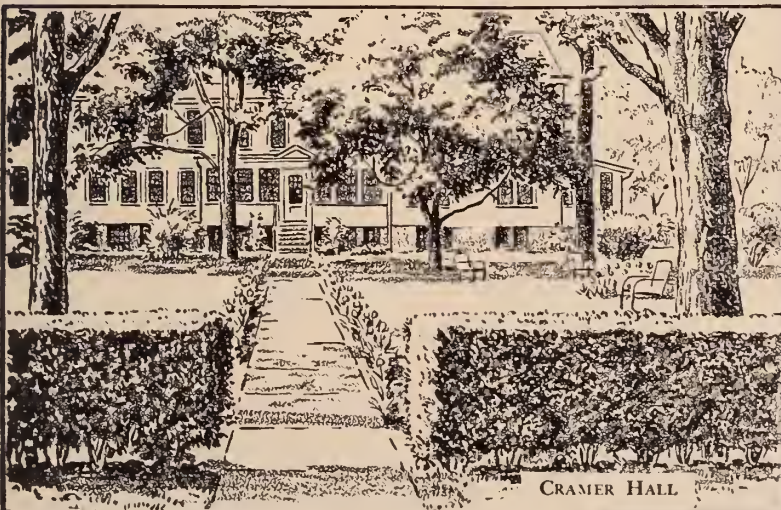
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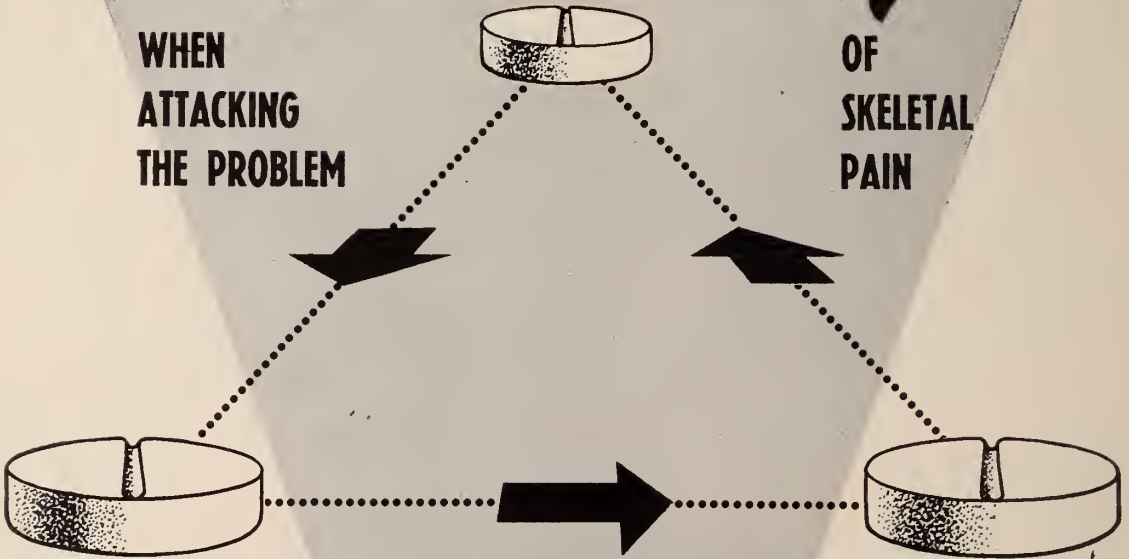
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in both **vagotonic** patients
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Obesity: One-half to one tablet 30 to 60 minutes before each meal. Anxiety and Depressive States: One-half tablet three times a day, or as determined by a physician.



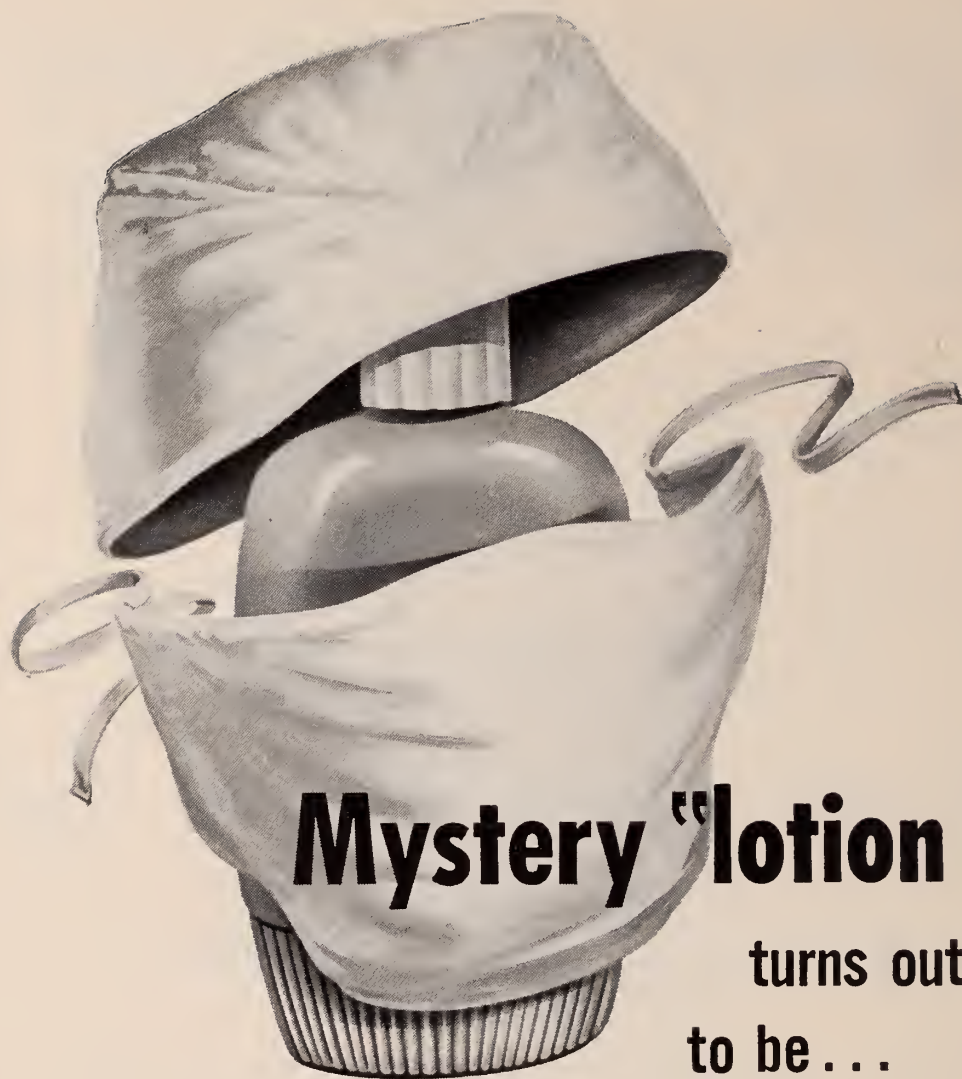
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Dextro Amphetamine Sulfate 5 mg
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REFERENCES

1. Freed, S. C. and Mizel, M.: Annals of Int. Med. June 1952
2. Dripps, R. D.: J.A.M.A. 139:148-150 (Jan. 15) 1949
3. Council on Pharmacy and Chemistry (Drug products used for obesity) (Prac. Phar. Ed) 8:436 (Sept.) 19

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In a report on a year-long study* of "Skin Rashes during the Newborn Period", the author** discusses the effects of two lotions used on infants . . . Lotion A and Lotion B.

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*Study conducted at The Hahnemann Medical College and Hospital of Philadelphia.

**Fischer, C. C. Clinical Study of Skin Rashes during the Newborn Period, Am. J. Dis. Child. 85: 688-693, 1953.

The very effective "Lotion B" turns out to be . . .
MENNEN BABY MAGIC SKIN CARE. You will find it as non-drying and helpful as did the author.

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14 DESIRABLE PROPERTIES... Veriloid



A selective alkaloidal extract of hypotensive principles obtained by fractionation from *Veratrum viride*. Representing less than 1% of the whole root, it is freed from the dross of the mother substance. It is generically designated alkavervir. In the management of hypertension it presents these desirable properties:

1 Biologic assay—based on actual blood pressure reduction in mammals—assures uniform potency and constant pharmacologic action.

2 Blood pressure is lowered by centrally mediated action; there is no ganglionic or adrenergic blocking.

3 Therapy is rarely, if ever, fraught with the danger of postural hypotension.

4 Hypotensive action is independent of alterations in heart rate.

5 Cardiac output is not reduced.

6 Renal function, unless previously grossly reduced, is not compromised.

7 Cerebral blood flow is not decreased.

8 Cardiac work is not increased, tachycardia is not engendered.

9 No dangerous toxic effects from oral administration, no deaths attributable to Veriloid have been reported. Side actions of sialorrhea, substernal burning, bradycardia, nausea, and vomiting (due to over dosage) are readily overcome and thereafter avoided by dosage adjustment.

come and thereafter avoided by dosage adjustment.

10 In broad use over five years, literally in hundreds of thousands of patients, no other sequelae have been reported, whether Veriloid is given orally or parenterally.

11 Tolerance or idiosyncrasy rarely develops; allergic reactions have not been encountered. Hence tablets Veriloid can be given for the long treatment needed in severe hypertension.

12 Continuing therapy with Veriloid has not led to interference with appetite or with excretory function.

13 Because of its rapidly induced, prolonged action (6 to 8 hours), tablets Veriloid provide around the clock hypotensive effect from 4 doses daily, make today's dosage effective today, and usually prevent hypertensive "spiking" during the night.

14 A notable safety factor in intravenous administration: *extent to which blood pressure is lowered is directly within the physician's control.*

Tablets Veriloid

The slow-dissolving, scored tablets are supplied in 2 mg. and 3 mg. potencies. In moderate to severe hypertension they produce gratifying response in many patients. According to published reports¹ this response can be maintained for long periods in fully 30% of patients; combination with other hypotensive agents has been credited with greatly increasing this percentage.² Initial daily dosage 9 mg., given in divided doses, not less than 4 hours apart, preferably after meals. To be increased gradually, by small increments, till maximum tolerated dose is reached. Maintenance dose 9 to 24 mg. daily.

Solution Intravenous

For immediate reduction of critically elevated blood pressure in hypertensive emergencies such as hypertensive states accompanying cerebral vascular disease, hypertensive crisis (encephalopathy), the toxemias of pregnancy. It lowers the blood pressure promptly, to any degree the physician desires, and with notable safety.³ If excessive hypotensive and bradycardic effects should be invoked they are readily overcome by simple means. Supplied in boxes of six 5 cc. ampuls. The solution contains 0.4 mg. of Veriloid per cc.

Solution Intramuscular

For maintenance of blood pressure in such critical instances, and for primary use in less critical situations which do not show the same immediate urgency. Provides 1.0 mg. of Veriloid per cc. in isotonic aqueous solution incorporating one per cent procaine hydrochloride. A single dose lowers the blood pressure significantly, reaching its maximum hypotensive effect in 60 to 90 minutes. By repeated injections (every 3 to 6 hours) blood pressure may be kept depressed for hours or days if necessary.⁴ Supplied in boxes of six 2 cc. ampuls. Complete instructions as to dosage and administration accompany every ampul of the parenteral preparations of Veriloid and should be noted carefully.

1. Kauntze, R., and Trounce, J.: Treatment of Arterial Hypertension with Veriloid (*Veratrum Viride*), *Lancet* 2:1002 (Dec. 1) 1951.
2. Wilkins, R. W.: Combination of Drugs in the Treatment of Essential Hypertension, *Mississippi Doctor* 30:359 (Apr.) 1953.
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Intravenous Administration of a Preparation of *Veratrum Viride* in Patients with Severe Forms of Hypertensive Disease, *New England J. Med.* 246:397 (Mar. 13) 1952.

4. Moyer, J. H., and Johnson, I.: Intramuscular Veriloid (Aqueous Solution) As a Hypotensive Agent, *Am. J. M. Sc.* 226:477 (Nov.) 1953.

ORIGINAL RESEARCH PRODUCTS OF

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Meats-in-a-Can

and Kitchen-Cooked Meats...

Comparative Nutritive Values

From a practical dietary standpoint, meats-in-a-can—preserved by commercial canning—are nutritionally interchangeable with meats of like variety prepared in the home.¹ For taste appeal, for economy and “keeping” quality, and for household con-

venience, meats-in-a-can are advantageous in many respects.

As the comparative data here shown indicate, kitchen-prepared meats and similar meats-in-a-can are closely alike in the amounts of various nutrients they provide.

COMPARATIVE COMPOSITION OF KITCHEN-COOKED AND COMMERCIAL-CANNED MEATS
(Nutrient Amounts per 100 Grams)

	*Kitchen-Cooked Ham ²	**Canned Ham ³ (Chopped, Cured)	Kitchen-Cooked Beef Round ²	Canned Roast Beef ²
Water	50%	50%	59%	60%
Protein	21 Gm.	20 Gm.	27 Gm.	25 Gm.
Fat (ether extract)	28 Gm.	20 Gm.	13 Gm.	13 Gm.
Niacin	4.0 mg.	4.3 mg.	5.5 mg.	4.2 mg.
Riboflavin	0.21 mg.	0.19 mg.	0.22 mg.	0.23 mg.
Thiamine	0.46 mg.	0.40 mg.	0.08 mg.	0.02 mg.

*Values after conversion from 42% to 50% water basis.

**Values after conversion from 58.69% to 50% water basis.

Experimental studies have shown that the processing which meats-in-a-can undergo leads to little if any greater vitamin losses than does home-cooking of similar cuts of meat. In general, meats-in-a-can retain of their original vitamin content approximately:

- 60 to 80 per cent of thiamine
- 90 to 100 per cent of riboflavin
- 90 to 100 per cent of niacin
- 80 per cent of biotin
- 70 to 80 per cent of pantothenic acid.^{4,5}

During storage for customary periods, at usual warehouse temperatures, meats-in-a-can show little, if any, further vitamin loss except in thiamine. Even thiamine, a highly thermolabile vitamin, was 52 per

cent retained in pork-in-a-can after ten months' storage at 80° F. Retention of the vitamin was notably greater when the canned pork was stored at 38° F.

Since meats-in-a-can are thoroughly cooked in processing, they may be consumed as purchased, merely warmed or mildly cooked. When the meat is moderately cooked in preparation for consumption, little or no further loss in vitamins need to occur.

Recent studies show that meats-in-a-can are excellent sources of needed amino acids.⁶ The 18 amino acids determined in these studies appeared in similar ratio and amounts in canned beef, pork, and lamb as in the respective fresh or home-cooked meats.

1. Howe, P. E.: Foods of Animal Origin, Handbook of Nutrition, American Medical Association, ed. 2, Philadelphia, The Blakiston Company, 1951, p. 637.

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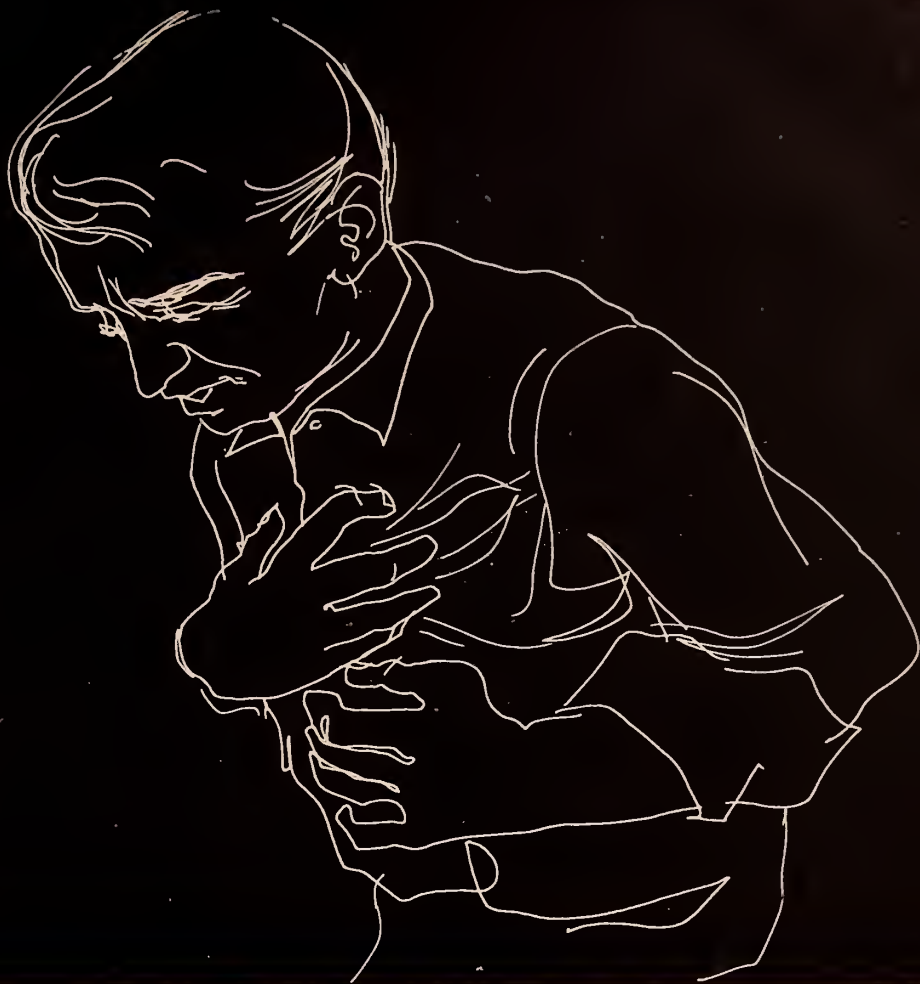
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The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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You can prevent attacks in angina pectoris

Prolonged protection

While Peritrate has been found effective in reducing the number of attacks in almost 80 per cent of patients,² comparison with nitroglycerin disclosed that Peritrate exerted "... a marked modifying influence on the electrocardiographic response to standard exercise ... comparable to [results] obtained with glyceryl trinitrate."¹ Unlike glyceryl trinitrate, this "*improved response could be elicited as long as four to five hours after administration of the drug.*"¹

Simple regimen

Together with significant improvement in the

EKG,^{1,2} Peritrate prophylaxis will reduce the nitroglycerin need in most angina pectoris patients.³ A continuing schedule of only 1 or 2 tablets 4 times daily will usually

1. *reduce the number of attacks in almost 80 per cent of patients²*
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Available in 10 mg. tablets in bottles of 100, 500 and 5000.

1. Russek, H. I.; Urbach, K. F.; Doerner, A. A., and Zohman, B. L.: J.A.M.A. 153:207 (Sept. 19) 1953.
2. Humphreys, P., et al.: Angiology 3:1 (Feb.) 1952.
3. Plotz, M.: New York State J. Med. 52:2012 (Aug. 15) 1952.

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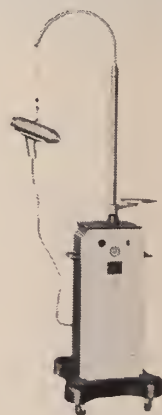
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Dextrose	130.0 mg.

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d1-Desoxyephedrine Hydrochloride	2.5 mg.
Methylcellulose	70.0 mg.
Magnesium Trisilicate	50.0 mg.
Calcium Gluconate	65.0 mg.
Dicalcium Phosphate Anhydrous	100.0 mg.
Sucrose	400.0 mg.
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(caution: may be habit forming)	
Methylcellulose	70.0 mg.
Magnesium Trisilicate	50.0 mg.
Calcium Gluconate	65.0 mg.
Dicalcium Phosphate Anhydrous	100.0 mg.
Sucrose	600.0 mg.
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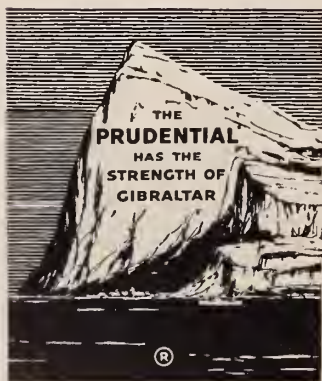
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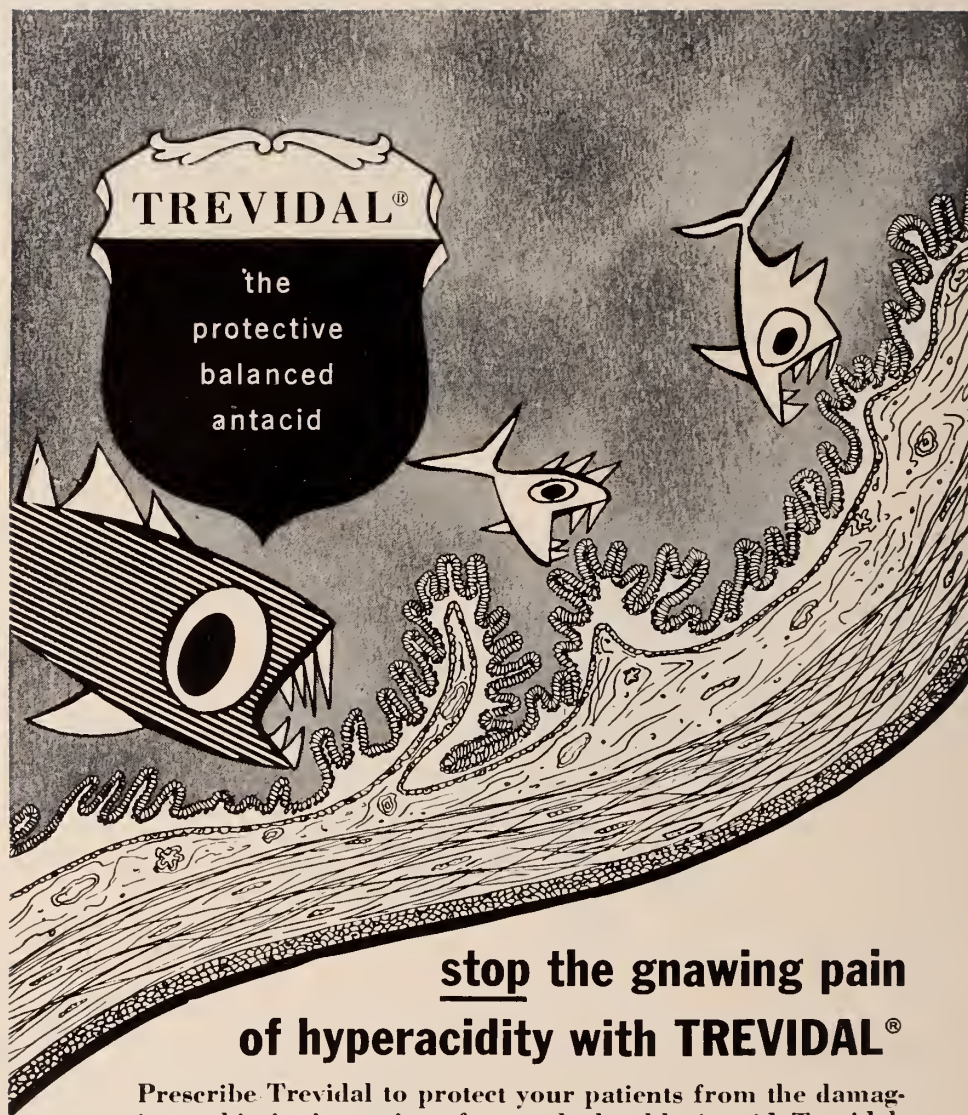
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1. Grayzel, H. G., Heimer, C. B., and Grayzel, R. W.: New York St. J. M. 53:2233, 1953.
2. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951.
3. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surgery. 18:512, 1949
4. Turell, R.: New York St. J. M. 50:2282, 1950.



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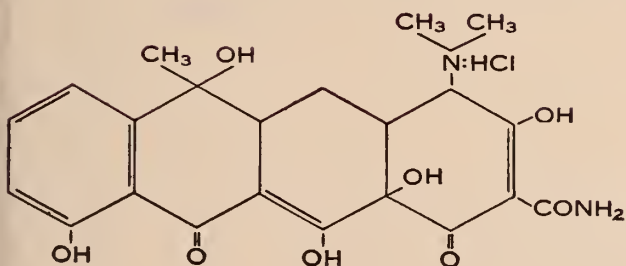
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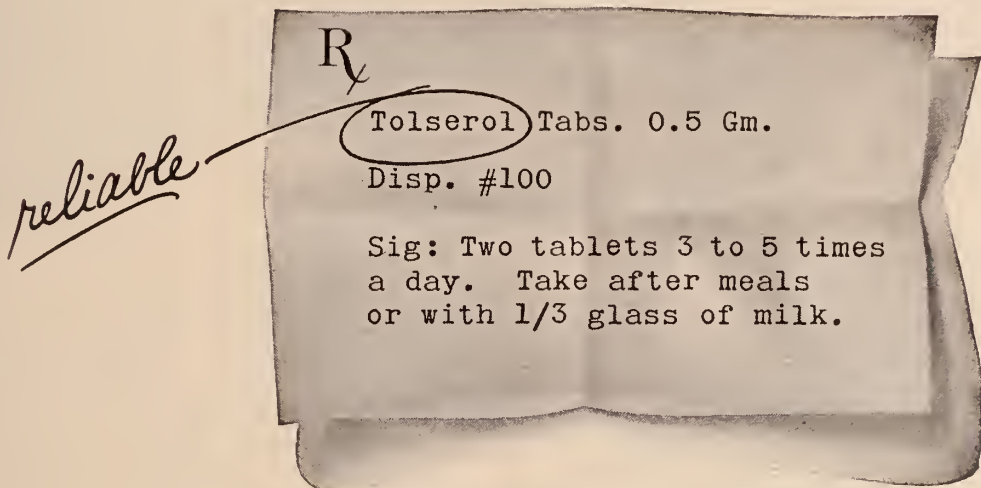
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*English, A. R., et al.: *Antibiotics Annual (1953-1954)*, New York, Medical Encyclopedia, Inc., 1953, p. 70.



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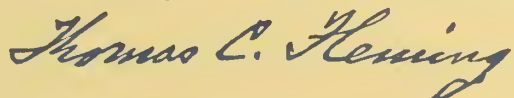
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1. Abramson, Julius, Bresnick, Elliott, and Sapienza, P. L.:
New England Jour. Med.,
243:44, July 13, 1950.

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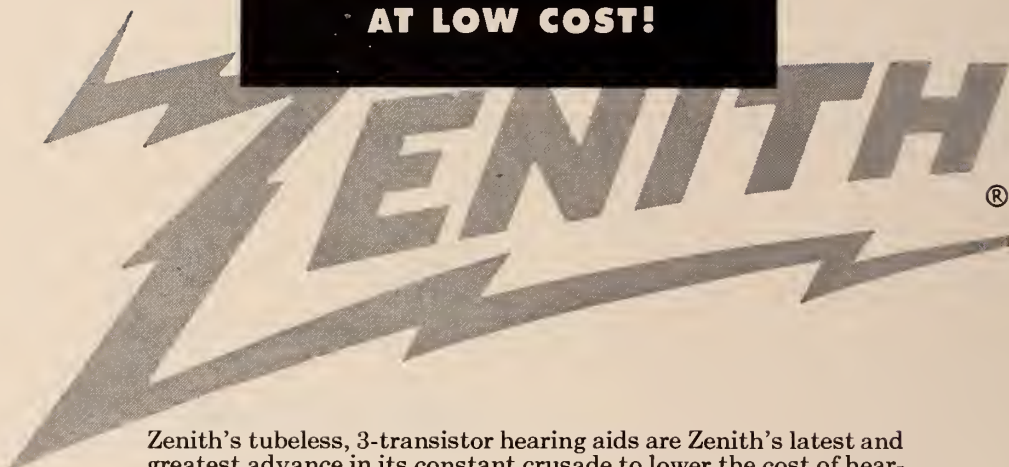
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*Stead, E. A., Jr., in Cecil, R. L., and Loeb, R. F.: Textbook of Medicine, ed. 8, Philadelphia, W. B. Saunders Co., 1951, p. 1065.

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POSTGRADUATE COURSES — 1954

SURGERY—Surgical Technic, Two Weeks, May 17, June 7, July 26. Surgical Technic, Surgical Anatomy and Clinical Surgery, Four Weeks, June 7, August 9. Surgical Anatomy and Clinical Surgery, Two Weeks, June 21. Surgery of Colon and Rectum, One Week, June 7. Thoracic Surgery, One Week, June 7. Esophageal Surgery, One Week, June 14. General Surgery, Two Weeks, July 26. Fractures and Traumatic Surgery, Two Weeks, June 7.

GYNECOLOGY—Office and Operative Gynecology, Two Weeks, June 7. Vaginal Approach to Pelvic Surgery, One Week, June 21.

OBSTETRICS—General and Surgical Obstetrics, Two Weeks, October 4.

MEDICINE—Two-Week Course September 27. Electrocardiography & Heart Disease, Two Weeks, July 12. Hematology, One Week, June 14.

RADIOLOGY—Clinical Diagnostic Course by appointment. Clinical Uses of Radio Isotopes, Two Weeks, June 7. Radiation Therapy, by appointment.

PEDIATRICS—Cerebral Palsy, Two Weeks, June 14. Congenital and Rheumatic Heart Disease in Infants and Children, One Week, October 11 and October 18. Two Weeks, October 11.

CYSTOSCOPY—Ten-Day Practical Course every two weeks.

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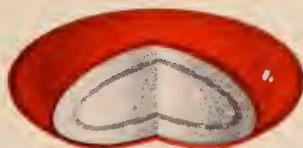
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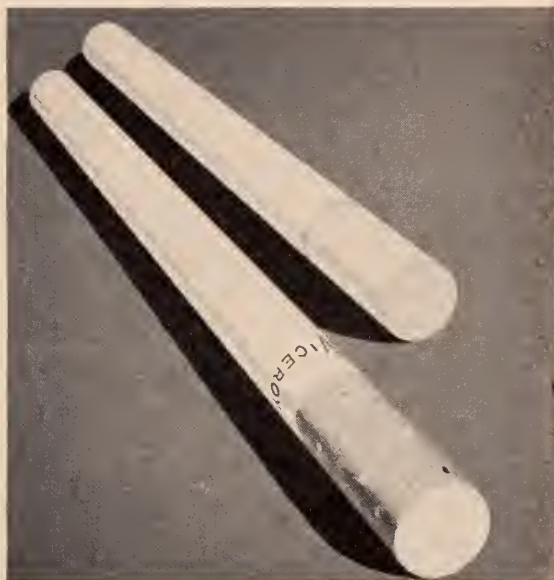
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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Present Status of the Medical-Dental School

HENRY B. DECKER, M.D., President

THIS message is an attempt to clarify the present status of the medical-dental school project. Some people have wondered just where it stands. Other have asked whether we are moving ahead and just what is being done.

Mrs. Mary G. Roebling, president of the Trenton Trust Company and a prominent figure in New Jersey, is the chairman of the Citizens' Committee. This committee's purpose is to develop interest in a medical-dental school and health center and to carry the story into each area of the state. Prominent people throughout the state in business, the professions (other than the medical and dental), the press, radio, and television, as well as many legislators, have accepted membership on this committee. At the appropriate time these people will be asked to enter actively into the movement in their respective areas of influence.

Governor Meyner, who was a member of the original Medical School Commission, has stated that the project is a legislative "must" during his administration. I understand he is anxious that a bipartisan bill calling for funds be introduced and submitted to the people in referendum during the November election. However, before the people's monies are sought, he wishes to exhaust the possibility of tapping private funds before this legislation is drawn. For this reason, no bill approved by the Medical and Dental Societies and the Governor's office has been submitted to the legislators. It is expected, however, that such a bill will be drawn within the next thirty days.

It is to be remembered that the Medical Society's efforts, as originally stated in the resolution adopted by the House of Delegates in 1948, endorsed the principle of an approved medical school under university auspices and supported by general tax funds.

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J. LAWRENCE EVANS, JR., M.D., *Chairman*

ROWLAND D. GOODMAN, 2d, M.D., *Editor*

MIRIAM N. ARMSTRONG, *Assistant Editor*

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The Annual Reports

Members of The Medical Society of New Jersey will find this issue of the JOURNAL of special interest. It contains, as have previous May issues, the annual reports of the many components that make up this Society.

Our society is organized along three principal branches—legislative, executive and judicial.

The legislative branch is composed of the House of Delegates which meets once a year at the annual meeting. The House of Delegates is composed of representatives of the twenty-one county medical societies and representation is apportioned approximately according to the number of members belonging to each county society. It is the duty of the House of Delegates to set the policies which the Medical Society will pursue. As with other similar legislative bodies, matters brought to its attention are referred to legislative committees—the so-called reference committees. These reference committees, after holding open hearings which any member, delegate or not, may attend and where he may express himself, consider the matters at hand and then refer them back to the House of Delegates for appropriate action. At the meetings of the House of Delegates itself, open debate on any subject may arise from the floor. Since the House and its reference committees only complete their activities during the annual meeting, the results of their deliberations are published in the *Transactions*, which appear as a supplement to this JOURNAL.

The judicial branch of our society consists of the Judicial Councils, each of which represents a district composed of four or five counties. These Judicial Councils consider matters, such as grievances, brought to their attention or referred to them from the judicial

councils or committees of the local county societies. Fortunately, in the past few years the number of grievances in this state has been so small that the judicial councils have served more or less in a standby capacity.

The executive branch of our society is headed by the Board of Trustees. To enable the board to function efficiently and well, several standing committees exist. These in turn refer appropriate subjects to subcommittees and advisory committees which consider the matters and then report back through the related subcommittee or standing committee to the Board of Trustees.

The Board of Trustees is also responsible for the day to day running of the society which is handled by a staff at society headquarters in Trenton under the executive officer and administrative secretary.

Besides the reports of organizations already enumerated, the work of certain adjunct groups intimately tied up with the program of our society. Their reports are included in this issue. These include the State Board of Medical Examiners, Medical Service Administration and Medical-Surgical Plan of New Jersey.

The reference committee to which each report is referred (except where otherwise indicated) appears just beneath the title.

The accomplishments, programs and future projects of these groups plus those of the county medical societies are published here. They represent the concerted effort of men willing to serve in positions of responsibility and they comprise our society's program for medical progress. For this reason, these reports are well worth the attention of every member of the society.

THE 188th ANNUAL MEETING OF THE MEDICAL SOCIETY OF NEW JERSEY

HADDON HALL, ATLANTIC CITY

May 16, 17, 18 and 19, 1954

DAILY SCHEDULE

Sunday, May 16, 1954

- 10:00 a. m.—Registration Opens
- 11:00 a. m.—Board of Trustees
- 2:30 p. m.—House of Delegates
- 6:00 p. m.—Reception to the Delegates and Their Wives. Sponsored by The Mennen Company (by invitation only)
- 6:30 p. m.—Auxiliary Fellowettes' Dinner (by invitation only)
- 8:30 p. m.—Nominating Committee

Monday, May 17, 1954

- 9:00 a. m.—Exhibits Open
- 10:00 a. m.—Section on General Practice
Section on Rheumatism
Section on Clinical Pathology
Section on Metabolism
Section on Eye, Ear, Nose, Throat
Section on Anesthesiology
Reference Committee "A"
Reference Committee "B"
Reference Committee "C"
Reference Committee "D"
- 12:30 p. m.—House of Delegates (election)
- 1:00 p. m.—Auxiliary Pre-Convention Board Meeting
Luncheons:
Section on Rheumatism
Section on Anesthesiology
Section on Eye, Ear, Nose, Throat
Section on Metabolism
Section on Clinical Pathology
- 2:00 p. m.—General Session on Medicine
Reference Committee "E"
Reference Committee on Constitution and By-Laws
Reference Committee on Miscellaneous Business
Reference Committee on Resolutions and Memorials

3:30 p. m.—Auxiliary Tea

All physicians' wives cordially invited

- 4:30 p. m.—Advisory Committee on Cancer Control and Medical Advisory Committee to New Jersey Division, American Cancer Society
- 5:00 p. m.—Council of the New Jersey Chapter, American College of Surgeons
- 6:00 p. m.—Exhibitors' Buffet-Supper (by invitation only)
Annual Dinner — New Jersey Branch, American Medical Women's Association
- 8:45 p. m.—General Session

Tuesday, May 18, 1954

- 9:00 a. m.—Auxiliary General Session
- 9:30 a. m.—House of Delegates
- 12:30 p. m.—Luncheons:
Woman's Auxiliary
Section on Surgery and New Jersey Chapter, American College of Surgeons
- 2:00 p. m.—General Session on Surgery
- 7:00 p. m.—Banquet

Wednesday, May 19, 1954

- 9:00 a. m.—Auxiliary Inaugural Breakfast
- 9:30 a. m.—Section on Pediatrics
Section on Gastro-Enterology and Proctology
Section on Neuropsychiatry
Section on Orthopedic Surgery
Section on Allergy
Section on Dermatology
- 10:00 a. m.—Auxiliary Post-Convention Board Meeting

12:30 p. m.—Luncheons:

Board of Trustees *

Section on Chest Diseases and New
Jersey Chapter, American College
of Chest Physicians

Section on Obstetrics and Gynecology

Section on Pediatrics

Section on Neuropsychiatry

Section on Gastroenterology and
Proctology

Section on Orthopedic Surgery

Section on Allergy

Section on Radiology

2:00 p. m.—General Session on Pediatrics,
Obstetrics and Gynecology

3:00 p. m.—Exhibits Close

4:00 p. m.—Registration Closes

GENERAL SESSION

Monday Evening, May 17, 1954

8:45 p. m.

Presiding: Henry B. Decker, M.D., President

National Anthem

"TRICKLE-UP PRESCRIPTION"

Inaugural Address:

Elton W. Lance, M.D., President-Elect

Mr. Roger Blough, Vice-Chairman, Board of
Directors, United States Steel Corporation

Musical Selections

Joseph Stern's Orchestra

An open meeting for all members of the Society
and the Woman's Auxiliary, representatives of
the allied professions, and the press.

BANQUET

Tuesday Evening, May 18, 1954

7:00 p. m.

honoring

HENRY B. DECKER, M.D., PRESIDENT

Toastmaster: Reuben L. Sharp, M.D.

Presentation of Fellow's Key:

Welcome: Mrs. Frank S. Forte, President, Woman's
Auxiliary

To: Henry B. Decker, M.D., President

By: Harrold A. Murray, M.D., Immediate Past-
President

Introductions: Mrs. Paul E. Rauschenbach,
President-Elect, Woman's
Auxiliary

NEW JERSEY STATE MOTTO, "LIBERTY AND
PROSPERITY"

Elton W. Lance, M.D., President-
Elect

Mr. Albert E. Meder, Jr., Dean of Administra-
tion, Rutgers University

Music:

Joseph Stern's Orchestra

SCIENTIFIC SESSIONS

Monday Morning, May 17, 1954

SECTION ON GENERAL PRACTICE

RICHARD R. CHAMBERLAIN, M.D., Chairman,
Maplewood

MORRIS A. MONALDY, M.D., Secretary, Passaic

10:00 a. m.

The Use of Topical Estrogens in Acne

Irving Shapiro, M.D., Clinical Assistant in
Dermatology, Beth Israel Hospital, Newark

Discussor: Aaron H. Horland, M.D., Newark

10:20 a. m.

Modern Approach to Therapy for the Chronic Alcoholic

Marvin C. Becker, M.D., Assistant Attending in
Medicine, Beth Israel Hospital, Newark

Discussor: Robert E. Erler, M.D., Maplewood

10:40 a. m.

Ingested Poisons, A New Instrument for Gastric Lavage

Richard Cupaiuoli, M.D., Assistant Attending in
Medicine, Orange Memorial Hospital, Orange

11:00 a. m.

Recess to View the Exhibits

11:20 a. m.

Business Session

11:30 a. m.

Proctology in Office Practice

Rudolph Gorsch, M.D., Clinical Professor of
Proctology, New York Polyclinic Medical School
and Hospital, New York, N. Y.

Discussors: Edwin Rosner, M.D., Collingswood
Charles H. Calvin, M.D., Perth
Amboy

SECTION ON METABOLISM

GEORGE M. KNOWLES, M.D., Chairman, Hackensack
OTTO BRANDMAN, M.D., Secretary, Newark

10:00 a. m.

Nephritis in Diabetes

Everett O. Bauman, M.D., Attending Physician
and Chief of Metabolic Service, Newark City
Hospital, Newark

Co-Authors and Discussors:

Otto Brandman, M.D., Attending Physician, St.
Michael's Hospital, Newark

Louis Grunt, M.D., Associate Physician, Meta-
bolic Service, Newark City Hospital, Newark

Selma Weiss, M.D., Attending Physician, East
Orange General Hospital, East Orange

William Nyiri, M.D., Attending Physician and
Chief of Metabolic Service, Newark City Hos-
pital, Newark

10:30 a. m.

Arteriosclerosis as a Disease of Metabolism

- Possible Etiology and Means of Prevention
- Management of Complications

Moderator:

George M. Knowles, M.D., Attending Physi-
cian, Hackensack Hospital, Hackensack

Panel:

Stewart F. Alexander, M.D., Park Ridge, At-
tending Physician, Hackensack Hospital,
Hackensack

James F. Gleason, M.D., Attending Physician,
Atlantic City Hospital, Atlantic City

John R. Wolgamot, M.D., Moorestown, At-
tending Physician, Burlington County Hos-
pital, Mount Holly

Albert G. Markel, M.D., Attending Physician,
Paterson General Hospital, Paterson

11:10 a. m.

Business Session

11:20 a. m.

The Use of Radioisotopes in Medicine with Special Reference to the Diagnosis and Treatment of Various Forms of Thyroid Disease

Joseph E. Rall, M.D., Assistant Professor of Medi-
cine, Department of Medicine, Sloan-Kettering
Division, Cornell University Medical College,
New York, N. Y.

Monday Morning, May 17, 1954

SECTION ON RHEUMATISM

W. ALAN WRIGHT, M.D., Chairman, Montclair

WALTER R. EDWARDS, M.D., Secretary, Trenton

10:00 a.m.

Conquering Rheumatism (Root of All Evil)

Richard T. Smith, M.D., Chief of Rheumatology,
Benjamin Franklin Clinic, The Pennsylvania
Hospital, Philadelphia, Pa.

Discussor: Herman H. Tillis, M.D., Newark

11:30 a. m.

Business Session

11:45 a. m.

Something Old, Something New

R. Winfield Betts, M.D., Medford, Instructor in
Medicine, Hahnemann Medical College, Phila-
delphia, Pa.

Discussor: Irving L. Sperling, M.D., Newark

SECTION ON ANESTHESIOLOGY

DURANT K. CHARLEROY, M.D., Chairman, Trenton

RODNEY C. TURNER, M.D., Secretary, Trenton

10:00 a. m.

Barbiturate Poisoning

James Eckenhoff, M.D., Department of Anesthe-
siology, University of Pennsylvania School of
Medicine, Philadelphia, Pa.

Discussors: Edward T. Lawless, M.D., Upper
Montclair
Nicholas Palma, M.D., Glen Rock

10:50 a. m.

Resuscitation of the Newborn

Robert Murphy, M.D., Anesthesiologist, Burlington
County Hospital, Mount Holly

Discussors: Cornelius J. Regan, M.D., Camden
Ralph Van Meter, M.D., Moores-
town

11:20 a. m.

Significance of the Body Fluids in Clinical Medicine

Joseph F. McCarthy, M.D., Associate, Department
of Anesthesiology, St. Francis Hospital, Trenton

11:45 a. m.

The Application of a New Drug RP4560 in
Anesthesiology

Ellis K. Hultzman, M.D., Chief of Anesthesiology,
West Jersey Hospital, Camden

12:20 p. m.

Business Session

SECTION ON CLINICAL PATHOLOGY

EDWIN H. ALBANO, M.D., Chairman, East Orange

ROBERT BRILL, M.D., Secretary, Passaic

10:00 a. m.

Symposium on the Management of Patients with
Fluid and Electrolyte Disturbances

Moderator: Arturo R. Casilli, M.D., Attending
Pathologist, Elizabeth General Hospital, Eliza-
beth

Donald A. Nickerson, M.D., Associate Professor of
Pathology, Boston University School of Medi-
cine, Boston, Mass.

William L. Rumsey, M.D., Attending Pediatrician,
Hospital of St. Barnabas and for Women and
Children, Newark

George L. Erdman, M.D., Attending Pathologist,
Overlook Hospital, Summit

Discussion from the floor

11:30 a. m.

Business Session

11:40 a. m.

The Hospital Tissue Committee: Its Organization
and Its Effectiveness

Robert Brill, M.D., Director of Laboratories, St.
Mary's Hospital, Passaic

Discussor: Henry V. Weinert, M.D., Passaic

Monday Morning, May 17, 1954

SECTION ON EYE, EAR, NOSE AND THROAT

ROBISON D. HARLEY, M.D., Chairman, Atlantic City

ROBERT F. ROH, M.D., Secretary, East Orange

10:00 a. m.

Symposium on Headache

William J. Grace, M.D., Associate Professor of
Medicine, Cornell University Medical College,
New York, N. Y.

Joseph G. Gilbert, M.D., Clinical Professor of
Otolaryngology, State University of New York
College of Medicine, Brooklyn, N. Y.

Michael Scott, M.D., Professor of Neurosurgery,
Temple University School of Medicine, Phila-
delphia, Pa.

Frank B. Walsh, M.D., Associate Professor of
Ophthalmology, Johns Hopkins University
School of Medicine, Baltimore, Md.

12:10 a. m.

Business Session

Monday Afternoon, May 17, 1954

GENERAL SESSION ON MEDICINE

CARROLL M. LEEVY, M.D., Chairman, Jersey City

PETER J. WARTER, M.D., Secretary, Trenton

2:00 p. m.

The Stevens-Johnson Syndrome

Dominic A. Mauriello, M.D., Chief of Medical
Service, U. S. Army Hospital, Fort Dix

2:30 p. m.

The Uses and Abuses of Sulfonamides and Anti- biotics

Perrin H. Long, M.D., Professor of Medicine, State
University of New York College of Medicine,
Brooklyn, N. Y.

2:55 p. m.

An Evaluation of Cholecystography in Liver Disease

Charles L. Cunniff, M.D., Associate Attending
Physician, Medical Center, Jersey City

3:15 p. m.

Current Concepts of the Etiology and Treatment of Coronary Atherosclerosis

Jeremiah Stamler, M.D., Research Associate,
Medical Research Institute, Michael Reese Hos-
pital, Chicago, Ill.

3:50 p. m.

Business Session

4:00 p. m.

Long-Term Use of Depo-Heparin in Myocardial Infarction

Irvin Sussman, M.D., Bridgeton, Chief of Medical
Service, Salem Memorial Hospital, Salem

4:20 p. m.

The Meaning of Diagnostic Tests Employed in the Evaluation of Thyroid Function

William H. Perloff, M.D., Director, Department of
Endocrinology, Temple University School of
Medicine, Philadelphia, Pa.

Tuesday Afternoon, May 18, 1954

GENERAL SESSION ON SURGERY

3:15 p. m.

Business Session

OTTO R. HOLTERS, M.D., Chairman, Asbury Park
GEORGE N. J. SOMMER, JR., M.D., Secretary, Trenton

2:00 p. m.

Surgical Treatment of Peptic Ulcer and its Complications

Earl J. Halligan, M.D., Chief Surgeon, St. Francis Hospital, Jersey City

Discussor: Andrew J. V. Klein, M.D., East Orange

2:35 p. m.

Cancer of the Skin—Surgical and Radiologic Aspects

William O. Wuester, M.D., Attending Surgeon in Malignant Diseases, Elizabeth General Hospital, Elizabeth

Discussors: James S. Gallo, M.D., Paterson
Emanuel M. Satulsky, M.D., Elizabeth

3:30 p. m.

Surgical Considerations of the Pancreas

Harold Zintel, M.D., Clinical Professor of Surgery, University of Pennsylvania Graduate School of Medicine, Philadelphia, Pa.

Discussor: B. Burrill Crohn, M.D., Consulting Gastroenterologist, Mount Sinai Hospital, New York, N. Y.

4:10 p. m.

Blood Volume in Surgery

C. Abbott Beling, M.D., Attending Surgeon, St. Vincent's Hospital, Montclair

Discussor: William G. Bernhard, M.D., Newark

Wednesday Morning, May 19, 1954

SECTION ON ORTHOPEDIC SURGERY

10:30 a. m.

JARVIS M. SMITH, M.D., Chairman, Montclair
OTTO LEHMANN, M.D., Secretary, Long Branch

9:30 a. m.

Fractures of the Hand

Eugene A. White, M.D., Assistant Attending Orthopedic Surgeon, New Jersey Orthopaedic Hospital, Orange

Discussor: Albert Willner, M.D., North Arlington

10:00 a. m.

Common Disabilities of the Upper Extremity

Charles I. Nadal, M.D., Attending Orthopedic Surgeon, Irvington General Hospital, Irvington

Discussor: Otto Lehmann, M.D., Long Branch

Common Nerve Injuries of the Upper Extremity

Robert E. Green, M.D., Attending Neurosurgeon, Hospital of St. Barnabas and for Women and Children, Newark

Discussor: Edwin J. Otis, M.D., Long Branch

11:00 a. m.

Shoulder Cuff Injuries

William G. Kuhn, M.D., Associate in Orthopedic Surgery, Middlesex General Hospital, New Brunswick

Discussor: John J. Flanagan, M.D., Newark

11:30 a. m.

Business Session

SECTION ON PEDIATRICS

10:00 a. m.

Recent Advances in Diseases of the Small Intestine

David Adlersberg, M.D., Assistant Clinical Professor of Medicine, Columbia University College of Physicians and Surgeons, New York, N. Y.

10:40 a. m.

Business Session

11:00 a. m.

Symposium on the Consideration of Functional Disorders of the Stomach

Moderator:

S. Bernard Kaplan, M.D., Chief of Gastro-Enterology, Beth Israel Hospital, Newark

1. Arthur J. Statman, M.D., Assistant Gastro-Enterologist, Beth Israel Hospital, Newark

2. David Adlersberg, M.D.

3. Abraham I. Friedman, M.D., Hackensack, Clinical Assistant in Gastro-Enterology, Mount Sinai Hospital, New York, N. Y.

MARTIN GREEN, M.D., Chairman, Atlantic City
WALTER L. MITCHELL, JR., M.D., Secretary, Newark

9:30 a. m.

Diagnosis and Treatment of Common Pediatric Orthopedic Conditions

John M. Naame, M.D., Chief of Orthopedic Service, Atlantic City Hospital, Atlantic City

Discussor: John J. Flanagan, M.D., Newark

9:55 a. m.

Diagnosis and Treatment of Acute Meningitis

Horace O. Bell, M.D., Senior Resident Physician, Essex County Isolation Hospital, Belleville

Discussor: E. Harrison Nickman, M. D., Atlantic City

10:20 a. m.

Business Session

10:40 a. m.

The Advantage of Early Diagnosis of Neurologic Conditions in Early Life

Eugene B. Spitz, M.D., Attending Neurosurgeon, Children's Hospital, Philadelphia, Pa.

Discussor: Edward P. Duffy, M.D., Belleville

SECTION ON DERMATOLOGY

EMANUEL M. SATULSKY, M.D., Chairman, Elizabeth
MORRIS H. SAFFRON, M.D., Secretary, Passaic

9:30 a. m.

The Tinea Capitis Problem in New Jersey

Frederick C. Licks, M.D., Attending Dermatologist, Essex County Isolation Hospital, Belleville

Discussor: Benjamin B. Burrill, M.D., Montclair

10:00 a. m.

Dermatologic Clues to Internal Disorders

Sol J. Fanburg, M.D., Associate Dermatologist, Clara Maass Memorial Hospital, Newark

Discussor: Herman Kline, M.D., Atlantic City

SECTION ON GASTRO-ENTEROLOGY AND PROCTOLOGY

S. WILLIAM KALB, M.D., Chairman, Newark
URBAN R. FINNERTY, M.D., Secretary, Montclair

9:30 a. m.

The Prophylaxis of Bowel Cancer

Maus W. Stearns, Jr., M.D., Rectal and Colon Service, Memorial Hospital, New York, N. Y.

Wednesday Morning, May 19, 1954

10:30 a. m.

Business Session

10:45 a. m.

Recent Advances in the Therapy of Common Dermatologic Conditions

Samuel M. Peck, M.D., Chief of Dermatology,
Mount Sinai Hospital, New York, N. Y.

Discussor: Henry B. Decker, M.D., Camden

SECTION ON NEUROPSYCHIATRY

GEORGE W. HAGER, JR., M.D., Chairman, Camden

EVELYN P. IVEY, M.D., Secretary, Morristown

9:30 a. m.

Interesting Deductions From Reclassification of Population at the New Jersey Neuro-Psychiatric Institute

Robert S. Garber, M.D., Medical Director, New Jersey Neuro-Psychiatric Institute, Skillman

Harry Brunt, M.D., Assistant Medical Director, New Jersey Neuro-Psychiatric Institute, Skillman

Discussors: Charles F. Deaterly, M.D., Moorestown

Daniel H. Stephenson, M.D., Camden

10:15 a. m.

An Evaluation of the Resistance of Patients to the Psychosomatic Approach

Vincent P. Mahoney, M.D., Chief Psychiatrist, Our Lady of Lourdes Hospital, Camden

Discussors: Wallace B. Hussong, M.D., Camden
William T. Snagg, M.D., Camden

11:00 a. m.

Business Session

11:15 a. m.

Neurologic Complications in Obstetrical Patients

David J. Flicker, M.D., Newark, Director of Neuropsychiatry, St. Mary's Hospital, Passaic

Discussors: Walter G. Scheureman, M.D., Trenton
Samuel A. Cosgrove, M.D., Jersey City

SECTION ON ALLERGY

WILLIAM B. NEVIUS, M.D., Chairman, East Orange

WILLIAM GREIFINGER, M.D., Secretary, Newark

9:30 a. m.

Psychosomatic Aspects of Allergy

Harold A. Abramson, M.D., Chief of Allergy Clinic, Mount Sinai Hospital, New York, N. Y.

General Discussion

10:10 a. m.

Pitfalls in the Management of the Allergic Child

Robert Chobot, M.D., Assistant Professor of Pediatrics, New York University-Bellevue Medical Center, New York, N. Y.

General Discussion

10:50 a. m.

Business Session

11:00 a. m.

Prevention of Allergic Reactions to Penicillin Injection

Eugene J. Luippold, M.D., Community Medical Group, Boonton

11:10 a. m.

Otolaryngologic Allergy

Henry Z. Goldstein, M.D., Attending Otolaryngologist, Beth Israel Hospital, Newark

General Discussion

Wednesday Afternoon, May 19, 1954

**GENERAL SESSION ON PEDIATRICS,
OBSTETRICS AND GYNECOLOGY**

3:20 p. m.

Pediatrics, MARTIN GREEN, M.D., Chairman,
Atlantic City
WALTER L. MITCHELL, JR., M.D., Secretary, Newark
Obstetrics and Gynecology, JOSEPH E. MOTT, M.D.,
Chairman, Paterson
HERSCHEL S. MURPHY, M.D., Secretary, Roselle

The Association of Pregnancy with Cancer of the
Breast and Cancer of the Cervix

William E. Finn, M.D., Assistant Professor of
Clinical Obstetrics and Gynecology, Cornell
University Medical College, New York, N. Y.

Discussor: Inglis F. Frost, M.D., Morristown

2:00 p. m.

Early Problems of the Newborn Infant

Harry H. Gordon, M.D., Pediatrician-in-Chief,
Sinai Hospital, Baltimore, Md.

Discussion from the floor

2:40 p. m.

Coagulation Defects Associated with Late Preg-
nancy Accidents

Duncan E. Reid, M.D., William Lambert Richard-
son Professor of Obstetrics, Harvard Medical
School, Boston, Mass.

Discussor: Felix H. Vann, M.D., Englewood

4:10 p. m.

Are There Medical Indications for Therapeutic
Abortions?

Joseph P. Donnelly, M.D., Attending Obstetrician,
Margaret Hague Maternity Hospital, Jersey
City

Discussor: Samuel G. Berkow, M.D., Perth
Amboy

4:50 p.m.

Business Session

HOUSE OF DELEGATES

President, Henry B. Decker, M.D., Camden

Secretary, Marcus H. Greiffinger, M.D., Newark

Sergeants-at-Arms: Benjamin F. Lee, M.D., Camden
Frank S. Forte, M.D., Newark

The Committee on Credentials will meet at the
Registration Desk each morning of the meeting.

SESSIONS

Second Session: 12:30 p.m., Monday, May 17, 1954

First Session: 2:30 p.m., Sunday, May 16, 1954

Order of Business:

- Order of Business:*
1. Call to Order
 2. Invocation
 3. Organization of House of Delegates
 4. Minutes of 1953 Meeting
 5. Introduction of Guests and Delegates from
Other States
 6. Annual and Supplemental Reports
 7. New Business
 8. Announcements
 9. Open Discussion on Medical-Surgical Plan

1. Report of Nominating Committee
2. Election

Third Session: 9:30 a.m., Tuesday, May 18, 1954

Order of Business:

1. Reports of Reference Committees
2. Unfinished Business
3. Installation of Incoming President
4. Adjournment

REFERENCE COMMITTEES

Monday Morning, May 17, 1954

Monday Afternoon, May 17, 1954

10:00 a. m.

2:00 p. m.

Reference Committee "A"

Reports of:

The President
The Board of Trustees
The Secretary
The Judicial Council
The Executive Officer

Reference Committee "B"

Reports of:

The Treasurer
The Finance and Budget Committee
The Publication Committee

Reference Committee "C"

Reports of:

The Medical Service Administration
The Medical-Surgical Plan
The New Jersey State Board of Medical Examiners

Reference Committee "D"

Reports of:

The Medical Defense and Insurance Committee
The Medical Education Committee
The Emergency Medical Service, Civil Defense Committee
The Medical School Committee
The Physicians Placement Service Committee
The Medical Research Committee

Reference Committee "E"

Reports of:

The Welfare Committee
The Subcommittees of the Welfare Committee
The Advisory Committees to the Subcommittees of the Welfare Committee

Reference Committee on Constitution and By-Laws

Amendments to the Constitution
Amendments to the By-Laws

Reference Committee on Miscellaneous Business

Reports of:

The Annual Meeting Committee
The Subcommittee on Scientific Program
The Subcommittee on Scientific Exhibit
Dates and place for the 1955 Annual Meeting
The Advisory Committee to the Woman's Auxiliary
Miscellaneous Business

Reference Committee on Resolutions and Memorials

Reports of:

The Honorary Membership Committee
Nominations for Emeritus Membership
Resolutions
Memorials

Reference Committee on Credentials meets at Registration Desk each morning of the meeting.

Woman's Auxiliary

To The Medical Society of New Jersey

TWENTY-SEVENTH ANNUAL MEETING

Sunday, May 16, 1954

6:30 p.m.—Fellowettes' Dinner
(by invitation only)

Monday, May 17, 1954

10:00 a.m.—Registration; Breakfast, Luncheon,
Dinner Tickets

1:00 P.M.—Preconvention Board Meeting

3:30 p.m.—Tea
All physicians' wives cordially in-
vited

8:45 p.m.—General Session of the 188th Annual
Meeting of The Medical Society of
New Jersey

The members of the Woman's Aux-
iliary are cordially invited to attend

Tuesday, May 18, 1954

9:00 a.m.—Registration; Breakfast, Luncheon,
Dinner Tickets

9:00 a.m.—General Session

Order of Business:

1. Invocation
Reverend John McMenamin
2. Pledge of Loyalty to the Woman's
Auxiliary to the American Medical
Association
Mrs. Edward H. Dyer, Immediate
Past-President
3. Welcome
Mrs. E. Harrison Nickman, Presi-
dent, Woman's Auxiliary to the
Medical Society of Atlantic
County
4. Response
Mrs. Paul E. Rauschenbach,
President-Elect
5. Memorial Service for Departed
Members
Mrs. Gerald E. McDonnel, Fellow-
ette
6. Convention Announcements
Mrs. Harry Subin, Chairman
7. Reports

12:30 p.m.—Luncheon

Honoring Mrs. Frank S. Forte,
President

Presiding
Mrs. David B. Allman

Greetings
Henry B. Decker, M.D., President,
The Medical Society of New Jersey

Guest Speaker
Mrs. Leo J. Schaefer, President,
Woman's Auxiliary to the Ameri-
can Medical Association

Presentation of President's Pin

To: Mrs. Frank S. Forte, President

By: Mrs. Edward H. Dyer, Imme-
diate Past-President

2:30 p.m.—General Session (continued)

Order of Business:

8. Reports and Discussion
9. Report of Nominating Committee
10. Election of Officers for 1954-55

7:00 p.m.—Banquet

Honoring Henry B. Decker, M.D.,
President, The Medical Society of
New Jersey

Wednesday, May 19, 1954

9:00 a.m.—Inaugural Breakfast

Speaker:
Elton W. Lance, M.D., President-
Elect, The Medical Society of New
Jersey

10:00 a.m.—Post-Convention Board Meeting

Mrs. Paul E. Rauschenbach pre-
siding

There will be an instruction session for new State
Officers, Chairmen and County Presidents im-
mediately following the Post-Convention Board
Meeting.

SCIENTIFIC EXHIBITS

Rutland Room, First Floor

Booth 1. Acute Upper Gastro-intestinal Hemorrhage. Irvin Sussman, M.D., Donald Berkowitz, M.D., Charles M. Thompson, M.D., Joseph Gambescia, M.D., Hahnemann Medical College and Hospital, Philadelphia, Pa.

The exhibit displays the essential points to be considered in the management of a patient with acute upper gastro-intestinal hemorrhage. Pertinent statistical data from experiences with 450 such cases seen at Hahnemann Hospital are presented. Prognostic significance of certain findings is also outlined.

Booth 2. Moles and Melanoma. Jeff Davis, M.D., George T. Pack, M.D., Memorial Hospital, New York, N. Y.

Pertinent and little known interesting facts about moles and melanomas will be presented together with their differential diagnosis, by means of diagrams, charts and color photographs. Indications for removal of nevi and choice of surgical procedures in the treatment of both primary and metastatic melanoma will be given with statistics and end results of treatment on 1225 cases of malignant melanoma.

Booth 3. Cancer of the Colon and Rectum. H. Wesley Jack, M.D., Camden, N. J.

Indicates how cases of cancer of the colon and rectum are to be handled; diagnostic steps and smears to be taken; care of colostomy and large bowel cancer; evaluation of five year cures.

Booth 4. Plasma Expander. William G. Bernhard, M.D., Harold Grubin, M.D., Abdol H. Islami, M.D., Houshang Hakim, M.D., Robert Brinning, M.D., Rita M. Knauf, M.T., Hospital of St. Barnabas and for Women and Children, Newark, N. J.

The exhibit consists of charts and transparencies illustrating the use of polyvinyl pyrrolidone, a satisfactory plasma expander in the emergency treatment of shock and its sequelae. There will be charts indicating the use of plasma expanders; summary of laboratory data showing the effect on organ function in 129 cases treated with plasma expander, with a follow-up period of over twelve months. Other charts will illustrate the various substitutes used as plasma expanders and the criteria for satisfactory plasma expanders. There will be ten transparencies illustrating blood pressure, and other data, showing the typical response in cases of shock with the use of polyvinyl pyrrolidone.

Booth 5. A. Perforated Cruciate Intramedullary Nail. Michael T. Modny, M.D.; **B. Guide for Insertion of Austin Moore Hip Nails.** Michael T. Modny, M.D., Harold G. Kunz, M.D., Mountainside Hospital, Montclair, N. J.

A. New type of intramedullary nail easily inserted through a single incision over the fracture site and completely contained within the medullary cavity.

B. Simple guide for the insertion of four parallel Austin Moore hip nails for use in intra-capsular fractures of femoral necks.

Booth 6. Lymphosarcoma in Childhood. Harold W. Dargeon, M.D., The Children's Tumor Registry, Memorial Center, New York, N. Y.

Lymphosarcoma during childhood is erroneously considered to have a universally hopeless prognosis. Certain features concerning the clinical course of 27 cases of lymphosarcoma in children and 5 cases who are surviving and well 5 to 19 years after the onset of their disease are illustrated.

Booth 7. Non-surgical Cholangiography. William H. Shehadi, M.D., New York Polyclinic Medical School and Hospital, New York, N. Y.

Non-surgical cholangiography is the term used to indicate a procedure which produces visualization of the biliary tract without surgical intervention. This may be performed by the oral administration of a cholecystographic medium known as Telepaque®, which in addition to bringing about adequate evaluation of the gallbladder, results in visualization of the extrahepatic ducts, especially of the normal cystic and common bile ducts. Variations from the normal and pathologic findings are also demonstrable.

In addition, the intravenous injection of Bili-grafin® will result in prompt excretion by the liver. This results in visualization of the major intrahepatic biliary radicles, as well as the extrahepatic bile ducts within 10 to 30 minutes. The value of this procedure is best demonstrated in cholecystectomized patients. In cholecystography, the gallbladder is visualized within approximately 2 to 2½ hours. In the examination of the gallbladder, this procedure should be limited to cases where the gallbladder does not visualize after oral administration of Telepaque®, and not as a routine procedure, since it is so time-consuming. Both contrast media have been investigated extensively in this department, and their non-toxicity and safety have been well established.

Booth 8. Rehabilitation of the Severely Disabled. Henry H. Kessler, M.D., Kessler Institute for Rehabilitation, West Orange, N. J.

The exhibit will present a graphic demonstration of the total rehabilitation process as it is applied to victims of severe disabilities. The teamwork approach among rehabilitation personnel will be stressed.

Booth 9—Evaluation and Results of Intracardiac Surgery for Pulmonic Stenosis. Robert P. Glover, M.D., Thomas J. E. O'Neill, M.D., C. Robert E. Wells, M.D., O. Henry Janton, M.D., Thomas McAuliffe, M.D., St. Christopher's Hospital for Children, Episcopal, Presbyterian, and Hahnemann Hospitals, Philadelphia, Pa.

This exhibit depicts the various types of pathology encountered in pulmonic stenosis. Pulmonic obstructions may be found within the pulmonary artery itself, within the pulmonary valve or within the outflow tract of the right ventricle proximal to the pulmonary valve. These obstructions may occur as a single defect, in combination with each other or in combination with other types of intracardiac defects. In each instance an intracardiac surgical procedure has been developed which satisfactorily relieves the pathologic obstruction and materially improves the patient's status for the future.

By employing transparencies depicting operative technics, methods of pre-operative evaluation and postoperative results, this exhibit clearly portrays the great advances which have been made with the conditions under question. To date the authors have had occasion to treat approximately one hundred such cases. The present status of this series of patients is clearly depicted.

Booth 10. Clinical Correlation of Allergic Symptoms and Mold Content of Air and House Dust.

Nathan Schaffer, M.D., Orange Memorial Hospital, Orange, N. J.; East Orange General Hospital, East Orange, N. J.; Edward E. Seidmon, M.D., Hunterdon Medical Center, Flemington, N. J.; Muhlenberg Hospital, Plainfield, N. J.

This exhibit will show the yearly incidence of culturable mold spores in air and house dust and results of testing and treating patients with symptoms not controllable with usual injections of house dust and pollen extracts. It will stress the importance of fungi in producing seasonal allergy, and the ability to control these symptoms by the injections of specific mold allergens.

The exhibit will consist of charts of yearly incidence curves of the airborne fungi spores recovered from 33 house dust samples, transparencies of the photomicrographs of the molds discussed, models of molds, cultures of the molds, and tables showing appearance of symptoms and skin testing results on a group of fifty patients.

Booth 11. Modern Therapy of Chronic Alcoholism. Marvin C. Becker, M.D., Beth Israel Hospital, Newark, N. J.; Ebbe C. Hoff, M.D., J. David Markham, M.D., Division of Alcohol Studies and Rehabilitation, Medical College of Virginia, Richmond, Va.

Presents a new approach to the therapy of chronic alcoholism as it may be handled by the internist, general physician, et cetera. It includes the selection of patients, the use of Disulfiram with its many ramifications, the value of psychotherapy, supportive follow up, et cetera. Results of therapy are indicated. The exhibit is profuse with illustrations showing the various physiologic reactions due to Disulfiram—alcohol reaction. How this reaction is controlled is also demonstrated.

Booth 12. Intra-articular Hydrocortisone. John W. Gray, M.D., Evelyn Z. Merrick, M.D., Newark, N. J.

The rationale of the use of intra-articular hydrocortisone therapy. Practical methods of technic. Evaluation of results in the treatment of 2,000 involved joints over a period of more than two years.

Booth 13. Estrogens and Acne. Irving Shapiro, M.D., Newark, N. J.

Treatment of acne using locally applied sodium estrone lotion and vanishing cream over a six year period. About 100 cases of chronic severe cystic types were studied which had relapsed following x-ray, diets, ultra-violet rays and vaccines, using an initial dose of 1 mg/cc. estrogen lotion twice a day. Eighty per cent of these cases improved within 6 weeks and further reduced dosage and treatment for several months produced satisfactory results. About 5% of the cases needed higher and another 5% lower concentrations.

Saturation of dosage levels is easily noted, with manifestations such as tender nipples, delayed menses; when dosage is sharply cut they are reversible and unimportant.

Advantages of local versus systemic treatment of acne are stressed, notably the low incidence and control of side reactions and rapid remission rate.

Tables are given listing causes of recurrence, time interval of expected changes, end points and side effects.

Before and after photos of typical cases are shown.

Booth 14. Visceral Granuloma Due to Migrating Larvae of Ascaris Lumbricoides. T. K. Rathmell, M.D., J. Mora, M.D., P. Volodkevich, M.D., Department of Pathology, Mercer Hospital, Trenton, N. J.

Exhibit shows gross parasites and fresh ova as seen in stool examination, and visceral granulomata resulting from migrating larvae of *Ascaris lumbricoides*. Charts present life cycle of the parasite in man, results of stool examinations in Mercer Hospital laboratory and authors' summary.

Booth 15. Hydrocortisone Therapy in Rheumatic Diseases. Irving L. Sperling, M.D., Newark, N. J.

Exhibit aims at describing the technic and results of therapy with hydrocortisone both orally and intra-articular.

Indications, dosage, contra-indications and therapeutic usage will be described.

Pictures illustrating technic of intra-articular usage will also be exhibited.

Booth 16. The Gallbladder Story. Paul L. Shallenberger, M.D., Donald Clough, M.D., Henry Perry, M.D., Guthrie Clinic, Robert Packer Hospital, Sayre, Pa.

The gallbladder story is presented to cover this disease problem from basic physiology of the liver and gallbladder through the commonly encountered clinical disease patterns. A brief discussion of function of the liver and gallbladder is presented with charts and pictures. A large color transparency, 30 by 40 inches, of the normal gallbladder and biliary tract is featured. After discussing in chart form numerous types of pathology encountered, the findings are summarized and a group of 650 consecutive cholecystectomies analyzed as to morbidity, mortality, and associated diseases.

Booth 17. Clinical Observations on Portal Cirrhosis. Carroll M. Leevy, M.D., Myra R. Zinke,

M.D., Thomas J. White, M.D., Angelo M. Gnassi, M.D., Felix Traugott, Medical Center, Jersey City, N. J.

This exhibit is based on a study of 250 patients with portal cirrhosis. It is presented (1) to describe certain mechanisms in the development of portal cirrhosis; (2) to evaluate the management of the patient with bleeding esophageal varices or ascites or mental changes; (3) to analyze the influence of portal cirrhosis on other disease states; and (4) to demonstrate the reversibility of clinical, biochemical and histologic abnormalities in the early phases of this disease.

Booth 18. Pathology of the Ureter. I. Maisel, M.D., M. Malament, M.D., East Orange Veterans Hospital, East Orange, N. J.

Reviews the diseases of the ureter and presents x-rays and color photographs of unusual pathology of the ureter.

Booth 19. Operative Cholangiography. Harold A. Kazmann, M.D., Peter J. Guthorn, M.D., Monmouth Memorial Hospital, Long Branch, N. J.

Advantages, special indications for, and technics of operative cholangiography. Outline of the normal anatomy and variations of the extrahepatic biliary system. Summary of experience in a representative number of routine operative cholangiograms.

Booth 20—Infrapubic Prostatectomy. J. Sydney Ritter, M.D., A. A. Johnson, M.D., Henry Ritter, Jr., M. D., McCarthy Urological Clinic, New York Polyclinic Hospital, New York, N. Y.

This exhibit contains illustrations demonstrating the procedure which has been developed over the past eight years. It is a direct approach to the prostate gland through the anterior triangle of the perineum, so that there is no damage to any of the nerves or vessels pertaining to the perineum or urinary sphincters. This approach is most satisfactory because of the minimum effect on the general well being of the individual. It is of particular value in those cases presenting other sinuses on the abdomen such as fistulae or colostomies. Bleeding is readily controlled by means of suture and the solusponge. A moving picture demonstrating the technic will be shown in the booth.

Booth 21. Recurrent Intestinal Obstruction: A New Method of Treatment. Victor P. Satinsky, M.D., Samuel D. Kron, M.D., Einstein Medical Center, Philadelphia, Pa.

A new method is presented for the treatment of recurrent intestinal obstruction. Recurrence is prevented by "controlling adhesions," which fix the intestine in an "orderly arrangement." This is accomplished surgically by a non-suture technic: the bowel is completely mobilized and then pleated along a semi-rigid, wide-bored, multi-perforated tube which is held taut by two fixation points. The method has been applied successfully in a variety of cases and seems to offer distinct advantages over suture-plication. Included in the exhibit are: an outline of rationale, advantages and indications; description of technic, with photos and a model, abstracts of illustrative cases with results.

Booth 22. Hypobaric Sacral Anesthesia in Anorectal Surgery. Emil Granet, M.D., Maurice B. Kagan, M.D., French Hospital, New York, N. Y.

For anorectal surgery the inverted jackknife position should generally supplant the lithotomy position. Its advantages are noted. The inverted position is suited to the use of hypobaric (light) anesthesia. Advantages of hypobaric saddle block include: (1) easy administration by thecal puncture with patient already in the inverted operating position; (2) minimal amount of drug, Nupercaine (2 to 3 mg.); (3) drug in hypobaric solution floats upward to localize about the sacral nerves in the cauda equina; (4) duration of anesthesia—2 to 4 hours; (5) postspinal headaches are rare. In the inverted position spinal fluid pressure is negative, hence, minimal fluid leak. Clinical observations are discussed.

Booth 23. Ballistocardiography. Aaron J. Heisen, M.D., Mercer Hospital, Trenton, N. J.; Albert J. Battaglia, M.D., Atlantic City Hospital, Atlantic City, N. J.

Demonstrates by posters the normal and abnormal ballistocardiographic observations of clinical interest and importance. Shows the various types of ballistocardiographs in actual operation.

Booth 24. Special Therapies. Robert S. Garber, M.D., Superintendent, New Jersey Neuro-Psychiatric Institute, Skillman, N. J.

This exhibit displays four large charts each showing the results of group psychotherapy for different categories of patients. Each chart shows the total number of patients involved and the percentages of those greatly improved, much improved, slightly improved and no change. In addition, there is presented a large number of 11 x 14 inch pictures of occupational therapy activities in shops and on wards together with a display of completed articles made by the patients. Patients are greatly benefited by having these activities prescribed.

The exhibit will show the number of patients treated, the number of patients improved by this treatment, the number ready for placement in the community, and the number already placed or discharged in one year's time.

Booth 25. Modern Methods of Testing Hearing. Robert F. Roh, M.D., East Orange; Mr. Herbert E. Rickenberg, Henry C. Barkhorn Memorial Hearing and Speech Center, Newark, N. J.

(1) Demonstration and usage of the Psychogalvonic Skin Response Test.

(2) Demonstration of conductance of the Audiological Evaluation and its interpretation.

(3) Descriptive charts of the Hearing and Speech Center, and literature on the services available.

Booth 26. Further Advances in the Early Diagnosis and Management of Atherosclerosis; Suggestive Evidence of its Arrest and Possible Reversibility. Joseph B. Wolfe, M.D., Anthony D. Dale, M.D., Edward I. Siegal, M.D., Ernest Jokl, M.D., Valley Forge Heart Institute and Fairview General Hospital, Fairview Village; Wolfe Clinic, Philadelphia, Pa.

The differential diagnosis of common arterial diseases will be illustrated by means of charts, with special emphasis on atherosclerosis. Diseases will be identified on the basis of the tentative classification of arteriopathies suggested by the Nomenclature Committee of the American Society for the Study of Arteriosclerosis.

Particular attention will be called to atherosclerotic hypertension as distinguished from the other hypertensive states—mainly the essential benign type from which it is rarely differentiated clinically.

The technic for roentgenologic examination of the abdominal aorta as an aid in the diagnosis of atherosclerosis will be given in detail. We consider palpation of liver and peripheral blood vessels as well as blood chemistry of utmost importance in early diagnosis of atherogenesis.

Latest methods in treatment of atherosclerosis from the viewpoint of disturbed metabolism will be outlined. The effectiveness of lipolytic and oxytropic therapy, particularly Betain and Polypancrine, will be shown. The method for preparation and administration of intravenous infusions of ether-alcohol in either dextrose or levulose in more advanced cases will be presented. Photographs, electrocardiograms, x-ray plates and results of blood chemistry will be used to demonstrate evidence suggestive of possible arrest and reversibility of the atherosclerotic process.

The effect of "nutritional caloric plethora" in atherosclerosis with and without diabetes mellitus will be illustrated. The study made in this country,

Great Britain, Denmark, Finland and Sweden will be included.

Booth 27. Genetics in Modern Medical Practice. Edwin J. Grace, M.D., Grace Clinic, Brooklyn, N. Y.; Vernon Bryson, Ph.D., Cold Spring Harbor, N. Y.

In order to halt the dangerous trend of bacterial resistant strains continuously emerging, experimental and clinical evidence is presented showing the results of a study in chemotherapy on 500 inbred mice and over 800 cases, noting its direct bearing on present medical practice. The history of chemotherapy starts with the pioneer work of Ehrlich in 1907 by curing trypanosomal infections in mice with a known chemical compound (trypan red). An evaluation of these advances historically for each decade in this century is presented in order to emphasize the role of bacterial genetics in integrating for the clinician the reasons for using multiple chemotherapy topically and systemically.

Booth 28. Pulmonary Complications of ACTH and Cortisone: Roentgen Observations. N. Finby, M.D., J. A. Evans, M.D., I. Steinberg, M.D., Department of Radiology, The New York Hospital, New York, N. Y.

The pulmonary complications of ACTH and cortisone therapy may be classified as follows: (1) tuberculosis, miliary and pulmonary; (2) pulmonary congestion; (3) pulmonary infarction; and (4) pneumonitis of unknown etiology.

TECHNICAL EXHIBITS

Lounge Floor

Booth 1—P. Lorillard Company, New York, N. Y.—Manufacturers of *Old Gold* and *Embassy* Cigarettes, as well as *Briggs* Pipe Mixture and other famous tobacco products, will exhibit and demonstrate their new *Kent* Cigarettes with the exclusive Micronite Filter which takes out up to seven times more nicotine and tars than other filter cigarettes.

Booth 2—Medical-Surgical Plan of New Jersey, Newark, N. J.—A cooperative, community enterprise, representing a partnership between 5,200 Participating Physicians and more than 1,200,000 citizens of New Jersey. It is dedicated to the proposition that doctors and their patients can solve their mutual economic problems through voluntary effort. This exhibit is offered for the information of the Participating Physicians, whose cooperation makes it possible for Medical-Surgical Plan to render an increasing service to the profession and the public.

Booth 3—White Laboratories, Inc., Kenilworth, N.J.—Mol-Iron Panhemic®—New, complete hema-

tinic for effective oral therapy of all anemias responsive to known hemopoietic essentials. The B₁₂ activating potency of its unique intrinsic factor concentrate is established by clinical assay. Only one small capsule twice a day provides all known antianemic factors in addition to Mol-Iron®, the most effective iron therapy known.

Booth 4—Lederle Laboratories, Pearl River, N. Y.—You are cordially invited to visit our exhibit where you will find our representatives prepared to give you the latest information on Lederle products.

Booth 5—Ortho Pharmaceutical Corporation, Raritan, N. J.—Ortho cordially invites you to visit their exhibit. Featured will be their product for conception control, Preceptin® vaginal gel, designed for use without a vaginal diaphragm. Preceptin® vaginal gel has achieved an outstanding record of clinical effectiveness and has been widely acclaimed by the medical profession. Your inquiries on Preceptin® vaginal gel are invited.

Booth 6—Baby Development Clinic, Chicago, Ill.—Maternity Counselling Service offers demonstration material to aid in teaching expectant mothers: care and support of breast; support of abdomen and relief of back strain; personal cleanliness. Preparation for infant and child care aids on bathing; feeding; toileting; as well as care of feet. Material also available for well baby conferences.

Booth 7—Nepera Chemical Co., Inc., Yonkers, N. Y.—The Nepera exhibit features Biomydrin®, a new nasal spray which has been reported to be "effective as an antibiotic in clearing the nose of pathogenic organisms and purulent secretions." Biomydrin® contains thonzonium bromide (antibacterial, mucolytic, reduces surface tension), neomycin, gramicidin, thonzylamine hydrochloride (antihistaminic), and phenylephrine hydrochloride (vasoconstrictor). Three other preparations will be exhibited: Mandelamine® urinary antiseptic; Neohetramine®, antihistaminic; and Cholelyl®.

Booth 8—Saratoga Springs Authority, Saratoga Springs, N. Y.—Theme: "The Saratoga Spa—one of New York State's health assets." This new exhibit will answer for the physicians two questions: what is spa therapy and its medical indications? and, what is an approved spa? It also emphasizes that a health vacation is good preventive medicine. An attendant will distribute Saratoga Spa literature, etc.

Booth 9—Eisele & Company, Nashville, Tenn.—We will display our regular line of clinical thermometers, hypodermic syringes, hypodermic needles, ECO bandages and specialty glassware.

Booth 10—The Wm. S. Merrell Company, Cincinnati, Ohio—

Booth 11—A. H. Robins Company, Inc., Richmond, Va.—Entozyme®, comprehensive digestant; Robalate®, antacid-demulcent; and Donnalate®, combining Robalate® with the Donnatal® formula are features at the A. H. Robins exhibit. Also shown are Pabalate®, Pabalate-Sodium free® and Allbee with C.® Robins' representatives welcome the opportunity to discuss with physicians the therapeutic advantages of these and other Robins prescription specialties.

Booth 12—Carroll Dunham Smith Pharmacal Co., New Brunswick, N. J.—Our exhibit will feature Lipotriad® (Smith) a new unusually potent lipotropic and oxytropic product, in both liquid and capsule form for the treatment of many conditions associated with faulty fat metabolism. Our representatives will also welcome the opportunity to discuss Bistrimate®, Calferbee®, Hemo-Vitol®, Neo-Sedaphen® and other specialties.

Booth 13—The Upjohn Co., Kalamazoo, Mich.—Featured will be Cortef® brand of hydrocortisone. Reports from clinicians and practitioners reveal dramatic results in the use of Cortef® where cortisone is indicated. Cortef® is available in tablet or ointment form for oral or topical use. Upjohn rep-

resentatives will welcome the opportunity to furnish additional information to the profession.

Booth 14—Medco Products Co., Philadelphia, Pa.—

Booth 15—George A. Breon & Company, Rensselaer, N. Y.—Distributors of Lanteen products, invites convention members to their exhibit of reproductions of well-known paintings by famous European artists. Lithographic prints of these beautiful paintings are available upon request. Representatives will also be happy to discuss Lanteen products with visiting members.

Booth 16—Ciba Pharmaceutical Products, Inc., Summit, N. J.—The Ciba exhibit will feature Serpasil®, a pure crystalline alkaloid of Rauwolfia which usually produces mild, gradual sustained lowering of blood pressure with a slowing of the pulse rate. Representatives in charge will be pleased to discuss the role of Serpasil® in the treatment of hypertension and to furnish literature on this new drug.

Booth 17—Ayerst Laboratories, New York, N. Y.—Physicians are cordially invited to visit the Ayerst booth where you will receive a warm welcome. Our representatives will be on hand to answer any inquiries relative to Premarin®, Mediatric® Liquid and Capsules, Kerodex®, or any other inquiries relative to all products of our manufacture.

Booth 18—Beech-Nut Packing Company, New York, N. Y.—Have you used the Beech-Nut Strained and Junior Foods for your geriatric as well as your pediatric patients? Beech-Nut nutritionists will be present to answer any questions you may have regarding the products available for special feedings.

Booth 19—The S. E. Massengill Company, Bristol, Tenn.—You are invited to visit our booth. Adrenosem®, the new Massengill systemic hemostatic, is featured. Adrenosem® is a specific in treating those conditions characterized by increased capillary permeability. Our representatives will be glad to discuss with you the latest information and clinical evaluation of this product.

Booth 20—J. B. Roerig and Company, Chicago, Ill.—Attending physicians are cordially invited to visit our exhibit where information is available on Tetracyclins®, the newest broad spectrum antibiotic. Professional Service representatives will be glad to supply samples, literature and clinical data on the efficacy of this basic antibiotic which can make your patient afebrile in hours, in the great variety of infections caused by a wide range of microbial invaders. Information, samples and literature will also be available on our well known nutritional products, such as Viterra®, Viterra Therapeutic®, Heptuna Plus®, Amplus®, Obron®, Obron Hematinic®, etc.

Booth 21—Warner-Chilcott Laboratories, New York, N. Y.—Two important cardiovascular agents

will be featured at the Warner-Chilecott booth: Methium®—to lower blood pressure and relieve hypertensive symptoms, and Peritrate®—to prevent attacks in angina pectoris. A new drug, Parsidol®—for the efficient management of Parkinson's disease, will also be exhibited. Representatives and research personnel will welcome an opportunity to discuss these drugs with you.

Booth 22—Brewer & Company, Inc., Worcester, Mass.—This exhibit consists of specialties centering around Thesodate®, the original enteric-coated tablet of theobromine sodium acetate; and Luasmin®, a combination of theophylline sodium acetate, phenobarbital, and ephedrine for the treatment of asthma. Also, Brewer capsules and ampuls, other specialties including Soduxin® (sodium succinate—Brewer) and standard pharmaceuticals manufactured by Brewer & Company, Inc., including a complete line of vitamin preparations for internal use and injection. In addition, the company's representatives will feature Asteric®, a special enteric-coated aspirin for massive dosages. Literature will be available on the new Brewer specialties, Injectable Quinidine Hydrochloride®, and Sus-Phrine® (aqueous suspension of epinephrine 1-200, Brewer).

Booth 24—J. Beeber Co., Inc., Philadelphia, Pa.—A complete line of medical, x-ray and physiotherapy equipment for the doctor's office and hospital will be presented. Included among the items on display will be the Cardiall® direct writing electrocardiograph, the greatest value in high accuracy; the Raytheon Microtherm®, the leader in diathermy apparatus; Mattern® x-ray equipment of all sizes and capacity. Courteous representatives will be on hand to assist the physicians visiting the booth.

Booth 25—Parke, Davis & Company, Detroit, Mich.—Medical service members of our staff will be in attendance at our exhibit for consultation and discussion of various products of particular interest to members of the association. Important specialties, such as Milontin®, Amphetase®, Penicillin S-R®, Benadryl®, Ambodryl®, Dilantin Suspension®, vitamins, Oxycel®, Thrombin Topical®, etc. will be featured. You are cordially invited to visit our exhibit.

Booths 26-27—R. J. Reynolds Tobacco Company, Winston-Salem, N. C.—Welcome to the Camel-Cavalier exhibit! You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of Camels, America's most popular cigarette, or Cavaliers, the king size cigarette of extra mildness and distinctive flavor.

Booth 28—Pet Milk Company, St. Louis, Mo.—Specially trained representatives will be in attendance to discuss the use of Pet Evaporated Milk in infant feeding and Pet Nonfat Dry Milk for high protein diets. A variety of services that are time-savers for busy physicians will be furnished on request. Miniature Pet Milk cans will be given to visitors at the exhibit.

Booth 29—Schering Corporation, Bloomfield, N. J.—Members and their guests are cordially invited to visit the Schering exhibit where new therapeutic developments will be featured. Representatives will be present to welcome you and to discuss with you these products of our manufacture.

Booth 30—Sharp & Dohme, Philadelphia, Pa.—The many indications for Hydrocortone® or Cortone® highlight the therapeutic importance of these hormones in everyday practice. Research data relative to more effective therapy when penicillin is used in conjunction with Benemid® (probenecid) completes the exhibit. Expertly trained personnel solicit discussion on these observations.

Booth 31—E. R. Squibb & Sons, New York, N. Y.—Raudixin®, the safe hypotensive agent will be featured. Raudixin® contains the whole root of Rauwolfia serpentina accurately standardized for uniform hypotensive and sedative effect. Our representative will be glad to discuss with you the advantages of Raudixin® used alone or in combination with other drugs.

Booth 32—Gerber Products Company, Fremont, Mich.—When milk is contraindicated as the basic food for infants, Gerber's Meat Base Formula can provide a nutritionally adequate replacement. It is well accepted and tolerated by infants of all ages. Your Gerber detailman invites you to evaluate Meat Base Formula and the complete line of supplementary baby food. You are also invited to review new editions of Gerber's baby care and adult special diet booklets. Each is designed especially for distribution by physicians. Each provides non-controversial information in simple, easy-to-understand language. The service is complimentary.

Booth 33—Holland Rantos Company, Inc., New York, N. Y.—Physicians interested in medical contraception are cordially invited to discuss with H-R convention representatives the latest information on clinical and laboratory data concerning the efficacy of Koromex® products. On display also will be Nylmerate® Jelly and Solution Concentrate, well-known for their trichomonacidal, fungicidal, and bactericidal value.

Booth 34—Winthrop-Stearns, Inc., New York, N. Y.—Monodral® is a new, well tolerated, synthetic anticholinergic for peptic ulcer (gastric and duodenal), hyperacidity, pylorospasm, spastic and irritable colon. Monodral® has unusual gastric antisecretory power, producing temporary anacidity in many patients; Telepaque®, highly effective and well tolerated oral cholecystopaque medium, gives denser, clear cut pictures of the gallbladder and, in a substantial number of cases, also permits visualization of the biliary ducts.

Booth 35—Desitin Chemical Company, Providence, R. I.—Desitin Ointment®, the pioneer in external cod liver oil therapy. Indications: diaper rash, slow healing wounds, burns of all degrees, lacerations, hemorrhoids and fissures. Desitin Powder®, a unique, dainty medicinal powder sat-

urated with cod liver oil. Desitin Hemorrhoidal Suppositories with Cod Liver Oil®, coats anorectal area with soothing, lubricating cod liver oil, gives prompt relief of pain, allays itching. New Improved Desitin Lotion®, the original cod liver oil lotion, soothing, protective, mildly astringent and healing, in non-specific dermatitis, pruritus, poison ivy, etc.

Booth 36—Eli Lilly and Company, Indianapolis, Ind.—You are cordially invited to visit the Lilly exhibit. The display will contain information on recent therapeutic developments and will feature the story of the Lilly Junior Taste Panel. Lilly sales people will be in attendance. They welcome your questions about Ilotycin® (Erythromycin, Lilly) and other Lilly products.

Booth 37—W. B. Saunders Company, Philadelphia, Pa.—Among the new books of interest published by Saunders since last year's meeting are Mackie, *et al.*: *Manual of Tropical Medicine*—2nd edition; Child: *Hepatic Circulation and Portal Hypertension*; Conant: *Manual of Clinical Mycology*—2nd edition; Todd, Sanford & Wells: *Clinical Diagnosis by Laboratory Methods*—12th edition; and *Current Therapy 1954*. The *Pediatric Clinics of North America* are a new addition to our ever popular *Medical and Surgical Clinics of North America*. They are already filling their place in clinical medicine.

Booth 38—Smith, Kline & French Laboratories, Philadelphia, Pa.—We will feature Spansule® sustained release capsules—the revolutionary new oral dosage form. Just one Spansule® capsule, taken on arising, provides a uniform supply of medication throughout the day. Thus, Spansule® capsules offer you 3 advantages: (1) smooth, uniform action, (2) prolonged therapeutic effect, and (3) convenient once-a-day dosage.

Booth 39—Mead Johnson & Company, Evansville, Ind.—We will feature Lactun®, Mead's liquid formula for infant feeding; Poly-Vi-Sol® and Tri-Vi-Sol®, superior vitamin supplements for infants; Panalins® and Panalins-T®, new vitamin capsules based on the new National Research Council's recommendations for vitamin maintenance and therapy. Natalins®, the smaller, complete prenatal capsules and Mulcin®, the new orange flavored vitamin liquid, will also be shown.

Booth 41—Arthur G. Huson Company, West Orange, N. J.—Established in 1838 the Arthur G. Huson Company has for many years sold to the discriminating buyer permanent cast aluminum signs of all descriptions. These signs are constructed of an alloy that allows a 30% bend and return without breaking. Special designs in letters for buildings as well as the unusual in large cast plates makes this company outstanding, with only quality products to offer. The Huson plant, modern and attractive, can be visited by its many customers who will receive courteous attention as to their needs and constructive assistance regarding any special work. This is your special invitation, please accept it.

Booth 42—The Borden Company, New York, N. Y.—There's no better place to talk over the latest information on infant feeding than the Borden Prescription Products booth. On display is the complete line of Borden infant formula products for every feeding purpose or preference. If you're encountering hyperirritability or excoriation, you'll be interested in Bremil®, a formula patterned upon breast milk. If you suspect milk allergy in some of your patients, you'll find the answer in Mull-Soy®, leading hypoallergenic food. For prematures, or for digestive disturbances demanding low fat and high protein, Dryco® provides an ideal, flexible formula base. And, if your preference is for liquid products, you'll want the latest facts about Biolac®.

Booth 43—Wyeth Laboratories, Philadelphia, Pa.—The display will feature Bicillin®, the new long-acting penicillin compound in various forms: Bicillin® Injection (several strengths) for treatment of many infections caused by penicillin-sensitive organisms and for prevention of rheumatic fever; Bicillin C-R®, for use in general practice; Bicillin All-Purpose®, for prophylaxis and treatment in surgical infections; widely prescribed Bicillin Oral Suspension®, effective, stable and delightfully palatable and Bicillin Tablets®, useful, convenient oral form unaffected by gastric juice, hence can be taken without regard to meals. Also featured will be Phenergan®, powerful, long-acting antihistamine valuable in controlling all the allergic manifestations that are amenable to antihistaminic therapy, and Wydase®, the purified "spreading factor" hyaluronidase with a wide range of clinical applications.

Booth 44—Lissco Medical Co., Inc., Newark, N. J.—Lissco prides itself on being a complete medical service unit. Probably 99 per cent of the equipment, supplies, machines, medications, books, orthopedic appliances, or what have you are available. And what's more, the salesman that makes contact with you is a gentleman and pleasing to the eye and conscience.

Booth 45—Ames Company, Inc., Elkhart, Ind.—Clinitest®, for urine sugar is standardized. This assures uniformly reliable results whenever and wherever a test is performed—office, ward, clinic, or patient's home. Standardization not only curtails error, but saves personnel's time by elimination of preparing and mixing of reagents. Acetest® for acetonuria, Bumintest® for albuminuria, Hematest® for occult blood, and Ictotest® for bilirubin, will also be on display.

Booth 46—M & R Laboratories, Columbus, Ohio—Your Similac® representatives are happy to take part in this meeting. They are pleased to have the opportunity to discuss with you the role of Similac® in infant feeding. They have for you the latest *Pediatric Research Conference Reports*. Also available are current reprints of pediatric nutritional interest.

Booth 47—Hoffmann-La Roche, Inc., Nutley, N. J.—You will find two products of special interest

to the surgeon featured in the Roche display: the synthetic narcotic, Levo-Dromoran® for relief of severe pain; and the soluble, sulfonamide Gantrisin® for antibacterial action.

Booth 48—Walker-Gordon Laboratory Company, Plainsboro, N. J.—Our Certified Milk Farm is the world's largest farm producing certified milk. It includes over 2400 acres of farm land and 2690 cows, bulls and growing heifers. The farm was started in 1898 and has been producing a special high quality milk since that time. It is the only certified milk farm in the world with daily medical and veterinary supervision and a complete technical laboratory on the farm providing constant medical, laboratory and veterinary supervision 24 hours each day. It is the home of the famous Rotolactor, the purpose of which is to make possible the production of a cleaner milk. Walker-Gordon produces Certified Raw Milk, Certified Pasteurized Milk, Homogenized Vitamin D Milk, Fat Free Milk and Acidophilus Milk. It is distributed in the metropolitan areas of New York and Philadelphia and in the state of New Jersey by many leading milk dealers.

Booth 49—Bristol-Myers Products Division, New York, N. Y.—Here are four products you'll want to know about: Bufferin® antacid-analgesic. Acts twice as fast as aspirin, does not upset the stomach. Sal Hepatica®—effervescent saline laxative. Ammens® medicated powder—Relieves itching and burning skin. Discourages bacterial growth. Trushay®—The "beforehand" lotion. Helps keep hands smooth in spite of roughening scrubbing.

Booth 50—Coca-Cola Company, Atlanta, Ga.—Ice cold Coca-Cola® served by the courtesy and cooperation of the Coca-Cola Bottling Company of Atlantic City, N. J. and the Coca-Cola Company.

Booth 51—L. & B. Reiner, New York, N. Y.

Booth 52—The Mennen Company, Morristown, N. J.—Baby Specialists since 1880, Mennen will exhibit its famous line of Baby Care Products, consisting of sensational Mennen Baby Magic, famous Mennen Baby Oil, Mennen Baby Powder, Baby Soap and Baby Cream. Also being featured is that leader among foot powders, Mennen Quinsana.

Booth 53—Billmber-Knoll Corp., Orange, N.J.—Metrazol® has been the subject of intensive investigation in the past year in conjunction with fatigue and mental confusion in the field of geriatrics. Information concerning the advantages of Metrazol® as a vasomotor and respiratory stimulant, as well as a tonic, will be available. Our representatives will also be pleased to discuss the new Tensodin®, which is indicated in coronary and peripheral vascular diseases, as well as Bromural®, Dilaudid®, Quadrinal®, Phenobarb®, Theocalcin®, and Valoctin®.

Booth 54—Faulhaber & Heard, Inc., Newark, N. J.—Full particulars can be obtained on profes-

sional liability protection upon inquiry at the booth of the Official Broker. Individual protection is also available for professional employees, such as registered or graduate nurses, x-ray or laboratory technicians and physiotherapists.

Booth 55—E. & W. Blanksteen, Jersey City, N. J.—Medical Society of New Jersey members have continued to participate in a new high level of policyholder status under the group plan of accident and health insurance with the National Casualty Company, through the State Society's accident and health insurance brokers, E. & W. Blanksteen of Jersey City. More than 75 per cent of the eligible members of the State Society are insured under this program.

Booth 56—Baby Service, Inc., Newark, N. J.—New Jersey's leading diaper service, will be on hand once again to greet their friends of the medical profession. As in past years they will have their famous "Baby Service Rose" for each lady. The exhibit will feature diaper service for the home and the hospital with full explanations of the scientific reasons for the safety and superiority of Baby Service. Attending members of the Society and their guests are cordially invited to stop at the booth.

Booth 57—E. Fongera & Company, Inc., New York, N. Y.—Physicians are cordially invited to discuss with our professional service representatives new preparations of importance to their every day practice. Descriptive literature and samples of all products will be available.

Booth 58—South Jersey Surgical Supply Co., Red Bank, N. J.—Exhibiting for the fifth consecutive year, we will attempt as usual to bring before this meeting the very latest developments in surgical instruments and diagnostic equipment. Our entire staff will be on hand to greet our many friends in the Medical Society.

Booth 59—Lynn Pharmacal Co., Camden, N. J.—All of our many friends are cordially invited to tarry a few minutes at the Lynn Pharmacal booth, and we hope those whom we do not know will stop and say "hello." We are pleased to present for your consideration in dispensing or prescribing—Rabudex®, the 3 to 1 ratio of dextro to levo amphetamine in managing obesity; Mephenamide®, the triple acting, analgesic, muscle relaxor, sedative combination to relieve skeletal muscle spasm and pain; Cynaplex®, the potent, practical crude liver-B complex injection in which pain and sting is reduced to a minimum. Lynn Pharmacal Company extends to all its best wishes for a successful convention.

Booth 60—C. B. Fleet Co., Inc., Lynchburg, Va.—During the past fifty years Phospho-Soda® (Fleet) has been a symbol of elegance in sodium phosphate medication. Fleet Enema Disposable Unit — an enema solution of Phospho-Soda® (Fleet)— is a worthy companion product. The single

use unit simplifies and assures satisfying preparation for proctoscopy and as a routine enema it is a boon to the hospitalized patient.

Booth 61—V. Stuart Company, Chicago, Ill.

Booth 62—The Denver Chemical Mfg. Co., Inc., New York, N. Y.—Dencotar Ointment®—Dencotar Shampoo®—Dencotar® products contain specially processed crude coal tar free of inert sludge and low molecular irritants in irradiated vegetable oil containing ozonides. Dencotar Ointment® has a cosmetic type base—it is non-greasy. Dencotar Shampoo® contains specially processed crude coal tar in a castile soap base. Samples and literature will be available.

Booth 63—G. D. Searle & Co., Chicago, Ill.—You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research. Featured will be Vallestil®, the new synthetic estrogen with extremely low incidence of side reactions; Banthine®, and Pro-Banthine®, the standards in anticholinergic therapy; and Dramamine®, for the prevention and treatment of motion sickness and other nauseas.

Booth 64—The Baker Laboratories, Inc., Cleveland, Ohio—You are invited to visit the Baker booth where you will receive a cordial welcome. Baker's Modified Milk and Varamel®, two successful products for infant feeding, are on display. Baker representatives will be glad to discuss with you the practical application of Grade A milk, adjusted fat composition, zero curd tension, synthetic vitamins and other important factors which help to eliminate many of the problems in modern infant feeding.

Booth 65—The Liebel-Flarsheim Company, Cincinnati, Ohio—Manufacturers of electromedical equipment for over thirty-five years, cordially invite you to visit their booth in which their latest short-wave diathermy and Bovie electrosurgical apparatus will be available for examination and demonstration. Capable representatives will be on hand at all times, and we hope you will stop by so that we may become acquainted.

Booth 66—Clark & Clark, Wenonah, N. J.—Profetamine® Phosphate Chewing Gum containing 10 mg. of amphetamine phosphate monobasic racemic; 5 mg. and 10 mg. tablets . . . the central nervous stimulant of choice. Clarkotabs® — Improved — the original Triple-Formula obesity preparation containing Profetamine® phosphate monobasic. All physicians are cordially invited to stop by at our booth to relax and discuss our line of prescription specialties with our representatives.

Booth 67—Burrhoughs Wellcome & Co. (U.S.A.) Inc., Tuckahoe, N.Y.—Marezine® Hydrochloride brand cyclizine hydrochloride—controls nausea and vomiting of pregnancy, motion sickness, vertigo and radiation sickness without inducing drowsiness.

Syrup of Antepar® Citrate-brand piperazine citrate—eradicates pinworms, pleasant to take. Tricoloid®-brand tricyclamol, compressed, sugar-coated—new anticholinergic for relief of hyperacidity, functional diarrheas and gastro-intestinal spasm.

Booth 68—Cameron Surgical Specialty Company, Chicago, Ill.—As usual the Cameron exhibit is just a little bit different than all others. A visit to it is a good investment for any doctor, even though he is only interested in looking. Cameron instruments are the world's finest—in a class by themselves—but only slightly higher in price than others. We are the originators of the Radio Knife which is made in 7 sizes, one office model weighing only 10 pounds and very inexpensive. No finer electro-surgical units can be made. All Cameron units are exempt under F.C.C. restrictions and are A.M.A. accepted.

Booth 69—Doho Chemical Corporation, New York, N. Y.—We are pleased to exhibit: Auralgan®, the ear medication for the relief of pain in otitis media and removal of cerumen; New Otosmosan®, the effective, non-toxic ear medication which is fungicidal and bacterial (gram negative-gram positive) in the suppurative and aural dermatomycotic ears; Rhinalgan®, the nasal decongestant which is free from systemic or circulatory effect and equally safe to use on infants as well as the aged; and Rectalgan®, the liquid topical anesthesia, also for relief of pain and discomfort in hemorrhoids, pruritus and perineal suturing.

Booth 70—Sandoz Chemical Works, Inc., New York, N. Y.—Sandoz Pharmaceuticals cordially invites you to visit our display—Cafergot®, available in oral and rectal form for effective control of head pain in migraine and other vascular headaches; Hydergine®, a vasorelaxant with central and peripheral action useful in hypertension and peripheral vascular disorders and geriatric conditions; Beller-gal®, valuable as an autonomic inhibitor in a variety of functional ills—the volume of favorable clinical reports is constantly increasing; Fiorinal®, a new approach to therapy of tension headache and other head pain due to sinusitis and myalgia. Our representative in attendance will gladly answer questions about these and other Sandoz products.

Booth 71—Encyclopaedia Britannica, Inc., Philadelphia, Pa.—The big, new 1954 edition of Encyclopaedia Britannica, the most comprehensive revision in 186 years, will be offered on a most unusual basis during the 188th Annual Meeting. The Britannica World Atlas—the remarkable new Britannica 7 Language Dictionary, and two new services of great importance and value, make this special exhibit offer the biggest news in Britannica history. The details will be explained without obligation.

Booth 72—U. S. Vitamin Corporation, New York, N. Y.—Exhibit features Panthoderm Cream®, the new and strikingly effective anti-pruritic, healing ointment. Dermatoses, long-resistant skin les-

ions, topical ulcers and slow healing wounds show rapid clinical improvement. Pain, itching and irritation abate rapidly, with relatively few failures. Particularly low sensitivity index. Professional samples and literature will be distributed on Panthoderm® together with our other nutritional specialties, Methischol®, Vi-Aquamin®, Aquasol A®, Vi-Syneral® vitamin drops, etc.

Booth 73—Pfizer Laboratories, Brooklyn, N. Y.
—Bothered by motion-sickness? Stop by for your homeward-bound supply of new Bonamine®. Our exhibit includes Cortril®, the anti-inflammatory hormone, and other Pfizer-Syntex steroids; Terramycin® in a variety of practical dosage forms; and many other items from the world's largest producers of antibiotics.

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THE MEDICAL SOCIETY OF NEW JERSEY

ANNUAL REPORTS TO THE HOUSE OF DELEGATES

MAY 16, 17, 18 and 19, 1954

President

(Reference Committee "A")

HENRY B. DECKER, M.D., Camden

FREQUENTLY in life, the pleasure of anticipation surpasses the reality of experience. Such is not the case, I can testify, in conjunction with the presidency of The Medical Society of New Jersey. So many and varied are the subjects with which the Society properly concerns itself, so diversified the demands which regularly must be met, that the candidate approaching the year of his incumbency is naturally prey to the fear that the trials may prove more than he can readily bear and the pleasures fewer than he would like. My year as president has proved such fear quite groundless. It is true, there are many demands made upon one's time, and there are responsibilities which must be acquitted and occasional difficult decisions which must be made. But one soon realizes that in meeting the demands, in bearing the responsibilities, and in making the decisions, he is not alone. He is constantly assisted, and that most generously, by many who are both able and hearteningly willing to be of all possible aid.

At the time of my assumption of office, I was grateful for the honor of being chosen president of The Medical Society of New Jersey, but now as I come to the end of my term of service I am doubly grateful, because of the bounty of kindness and encouragement which everywhere I enjoyed.

TO MY fellow officers and the chairman and members of the Board of Trustees, to all committee chairmen and members, to the officers and members of the Woman's Auxiliary, and to all of the executive staff I shall be forever indebted for their consideration, cooperation, and encouraging support. I am conscious, too, of a cherished debt to the officers and members of component county societies for their courtesy and hospitality to me, frequently far exceeding the most extreme limits that even gracious politeness would dictate. This has been a year of stimulating discovery that there is so much not only of ability and industry but of incomparable good will brought to the service of The Medical Society of New Jersey and to the assistance of its president and other officers.

This sense of not being alone, which I have remarked, is a very salutary one. It enlarges the scope of one's plans and makes easier the way of accomplishment. It substitutes a happy spirit of interdependence for the disappointing and unsound attitude of boastful independence. We have proof of its effectiveness in the work of our liaison committees. I *recommend* the continuation and expansion of the process that is presently under way, to so organize, correlate, and unify our activities, within and without our Society, as to increase the effectiveness of all our efforts.

It has been a year of pleasant fulfillment. For it, my abiding thanks to all.

Treasurer

(Reference Committee "B")

JESSE MCCALL, M.D., Newton

AS THE fiscal year does not close until May 31, 1954, the annual report cannot be submitted at this time. An interim report will be

presented to the House of Delegates on May 16, 1954, covering the accounts to that date.

Secretary

(Reference Committee "A")

MARCUS H. GREIFINGER, M.D., Newark

THE office of the Secretary has continued to be an active one. Routinely, numerous communications have been promptly answered and questionnaires from various sources completed and returned. The Secretary attended the annual session of the A.M.A. in New York and the mid-winter meeting in St. Louis as well as meetings of the Board of Trustees and several committees of which he is a member or adviser.

membership benefits must necessarily be suspended and their insurance is jeopardized.

A. M. A. MEMBERSHIP

MUCH of the work of the Secretary's office is devoted to recording A.M.A. dues payments and to the preparation and transmission of reports to the A.M.A. office in Chicago.

1953 A.M.A. Dues—On December 31, 1953, we received notice from the A.M.A. that there were 4,948 members of The Medical Society of New Jersey enrolled as active members of the American Medical Association. According to our records, we had forwarded 5,011 memberships to the A.M.A. The membership count differed for the following reasons:

1. The Society considered all who paid 1953 A.M.A. dues as members in good standing. The A.M.A., on the other hand, did not consider those who owed dues for previous years as members in good standing, even if 1953 dues had been paid.

2. Some members whom the Society considered to be exempt from payment of dues by reason of service in the armed forces were not classified as active members exempt from payment of dues by the A.M.A., but were classified instead as "service members" and were not credited to New Jersey.

3. Other requests for exemptions were not concurred in by the A.M.A.

MEMBERSHIP

(As of March 31, 1954)

Active members—Paid	4,683
Exempt	196
Associate members	124
New and reinstated members	110
Members deceased (March 1953 -	
March 1954)	61
Transfer—within the state	9
Resignations and transfers out of state ..	13
State emeritus members	82
State honorary members	1
County emeritus and honorary members	103

At this time we would like to repeat the request made in previous reports that the county societies emphasize to their members the importance — even necessity — of maintaining membership in good standing at all times. Unfortunately, each year a number of members neglect to pay dues promptly, thereby allowing their membership to lapse. As a result, all

The number of A.M.A. delegates is based on 1 for each 1,000 active A.M.A. members or portion thereof. It is regrettable that New Jersey lacked but 53 to regain its 6th delegate for 1954.

1954 A.M.A. Dues—In December 1953 the A.M.A. House of Delegates approved a recommendation that members suspended for non-payment of 1950 dues be reinstated during the first six months of 1954 by payment of 1954 dues only.

As of March 31, 1954, 4,188 members of The Medical Society of New Jersey have been reported to the A.M.A. However, the A.M.A. has instructed us to return to the county societies 1954 dues payments for anyone owing dues for previous years. The county societies are asked to urge their members to settle all unpaid A.M.A. dues for previous years. If this is done, we are confident that the Society's 1954 A.M.A. membership will permit six New Jersey delegates in 1955.

MEMBERSHIP DIRECTORY

SINCE publication of the first edition of the Membership Directory last May, the work load has decreased, but an active program is being maintained for easy compilation and publication of the next issue. Some thought was originally given to the issuance of a supplement this year. However, a study of the small number of listings in comparison with the cost shows the supplement impractical. During the coming year work will be concentrated on the preliminary activities connected with the second edition. This edition will be issued in the fall of 1955 and will cover the maximum membership for the year. All members who have failed to complete and return their questionnaires are urged to do so, in order that the next issue be complete.

During the year, 173 directories have been sent to new and reinstated members; 222 copies have been sold; in all, 395 have been distributed to members or purchasers.

Board of Trustees (Reference Committee "A")

REUBEN L. SHARP, M.D., Chairman, Camden

THE report of the Board of Trustees highlights the Board actions of the year — all of which are reported in detail in the pages of the JOURNAL. While the number of meetings has been held to a minimum, the hours in session have been long. I wish to record my appreciation and gratitude to all the Board members for their loyal and diligent service in the interests of the Society, and to commend the dependable and orderly work of the several committees. The benefit of their generous endeavors greatly facilitated the conduct of the Society's business.

LIAISON COMMITTEES

IN ADDITION to the committees of liaison with the dental, hospital, and legal professions, the Board established liaison committees with the pharmaceutical and nursing associations. These committees are composed of high-level personnel through which information for subsequent action is brought directly to the board concerning matters of common interest.

COSPONSORSHIPS

BY INVITATION from the State Department of Health, the Medical Society cosponsored postgraduate courses in the early detection and

control of chronic disease and the governor's conferences on diabetes, alcoholism, and epilepsy. The Society will also cosponsor the Fifth Health Education Workshop of the New Jersey Tuberculosis League.

SPECIALTY SOCIETIES

A LETTER was sent to all specialty societies in the state urging that official requests for cooperation of the Medical Society be transmitted to the Board or the President as soon as projects have been well formulated. There has been a tendency on the part of specialty groups to launch projects without referral to the Medical Society, and at the last minute to attempt to induce the Board to precipitate action.

ANNUAL REPORTS REVIEW

BECAUSE in past years occasionally conflicting and even contradictory recommendations—concerning the same matter but originating in different committees—have been adopted by the House of Delegates, a special committee was appointed to review all annual reports before their submission to the House of Delegates. The review committee did a momentous job in culling all the reports before publica-

tion to make sure that the various items conformed to established policy and procedure.

EMERGENCY MEDICAL SERVICE, CIVIL DEFENSE COMMITTEE

IN ACCORDANCE with the action of the 1953

House of Delegates, calling for the establishment of a Committee on Emergency Medical Service, Civil Defense, such a special Committee was appointed to initiate a program for the guidance of all component county medical societies in this sphere of medical civil defense.

VETERANS MEDICAL SERVICES COMMITTEE

UPON the recommendation of the A.M.A., a Special Committee on Veterans Medical Services has been established. Through this state committee, the A.M.A. Committee on Federal Medical Services of the Council on Medical Service plans to maintain effective liaison to the end that the number of doctors intimately conversant with the A.M.A. attitude may be increased and that methods may be devised for getting action down to operational levels.

AMBULATORY PATIENTS

IT WAS brought to the attention of the Board that certain hospitals were soliciting physicians to send ambulatory patients to hospital departments for treatment and were making definite charges for such treatment. The Board reaffirmed its action of January 1948, "that the sending of ambulatory private patients to hospitals for x-rays, laboratory examinations, and physical therapy treatment be discouraged where adequate facilities are available in private physicians' offices," and appointed a special committee to meet with the boards of designated hospitals on the matter.

WORKMEN'S COMPENSATION

AN AMICABLE agreement was reached by a special committee of the Board and representatives of insurance companies and the Department of Labor on the possibilities of having medical problems arising in the State Workmen's Compensation Bureau referred for medical advice to The Medical Society of New Jersey rather than to some lay organization.

REFERRALS TO HOUSE OF DELEGATES

SEVERAL matters have been considered by the Board during the year and are referred to the House of Delegates for consideration:

Criteria for Medical Specialists (Reference Committee "C")

Following approval of the recommendation of Medical-Surgical Plan in 1953 "that consultations be eliminated as an eligible service," the House of Delegates approved the recommendation of Reference Committee "C" that the Medical Society establish qualifying criteria for the recognition of specialist consultants to whom payment may be made by the Plan in the future if feasible."

This subject was referred to the Subcommittee on Medical Practice which, with the approval of the Welfare Committee, proposes the following five points of criteria:

1. Board certification in the specialty involved in the consultation.
2. Fellowship in an approved College, such as the American College of Surgeons, American College of Physicians, etc.
3. Rank of attending, associate, or consultant in the specialty involved in the consultation in a hospital approved. Approved hospitals shall be those registered by the A.M.A., or approved by the American College of Surgeons, or which hold membership in the American Hospital Association.
4. Completion of an approved residency training and eligibility for Board examination in the specialty involved in the consultation.
5. Establishment of a committee in each component county medical society to pass on specialist qualifications of those within the county who do not qualify under any of the above four categories; recognition by the county committee to be approved by the Board of Trustees of the state society.

1955 Annual Meeting (Reference Committee on Miscellaneous Business)

Because the 1955 A.M.A. meeting is scheduled for June in Atlantic City, it was adjudged desirable that the annual meeting of the Medical Society be advanced from the middle of May to late April. Earlier dates were not available at Haddon Hall; therefore, the Board authorized the cancellation of the dates reserved at Haddon Hall for May, 1955, and the reservation of April 17-20, 1955, at the Hotel Ambassador for the 1955 annual meeting.

Subsequently, it was proposed that a convention-cruise to Bermuda be held in 1955. The proposal was submitted to the county medical societies. Up to the writing of this report, nine counties have voted favorably, two are opposed, and one county is equally divided.

No response has been received from the other nine counties.

The Board of Trustees is of the opinion that a convention-cruise would prohibit the attendance of those members who attend the annual meeting for only one or two days, and that it would not be in the best interests of the Society to try to carry out the business affairs and scientific sessions on a cruise. Therefore, the Board recommends that the convention-cruise not be adopted for 1955, but the 1955 annual meeting be held at the Hotel Ambassador, April 17-20, 1955.

Cardiac in Industry (Reference Committee "E")

The following item was submitted by the Advisory Committee on Cardiovascular Diseases, with the approval of the Subcommittee on Public Health and the Welfare Committee, for publication in the Membership News Letter and the JOURNAL. The Board refers the matter to the House of Delegates for further study.

It is the opinion of the Advisory Committee on Cardiovascular Diseases of The Medical Society of New Jersey that a good evaluation unit for the cardiac in industry should consist of a cardiologist, a vocational counselor, a social worker, and a psychiatrist, when necessary.

In many instances, at the present time, the position of the vocational counselor and the social worker may be more important in the successful management of an evaluation unit than the examining physician.

It should be emphasized that an evaluation unit is an advisory unit only and not a unit for treatment. When a patient is referred for evaluation, a report should be sent to the referring physician or agency and a copy of the report should be mailed to the treating physician.

Relationship Between Osteopaths and Medicine (Reference Committee "E")

As reported by our A.M.A. delegates, the most controversial issue at the June 1953 A.M.A. meeting in New York was the question of immediate or deferred action on the report of the Committee for the Study of Relations between Osteopathy and Medicine. The majority report of the Reference Committee, postponing action until June 1954, was adopted, allowing further study by the delegates and the state associations.

This item was referred to the Welfare Committee for study and report. The subject was discussed at the December 1953 meeting of the Welfare Committee and referred to the county medical societies for consideration. At the March 1954 meeting the following report was made by the county societies:

1. Should modern osteopathy be classified as "cultist" healing?

Yes — 3

No — 13

2. Should doctors of medicine teach in osteopathic schools?

Yes — 12

No — 4

3. Should the relationship between medicine and osteopathy be determined by the several state associations?

Yes — 13

No — 2

No replies have been received from Essex, Hudson, Hunterdon, Somerset, or Sussex counties.

The Board of Trustees refers this matter to the House of Delegates for study and recommendation.

Hospital Offenses (Reference Committee on Resolutions and Memorials)

A resolution from the Hudson County Medical Society, adopted by the 1953 House of Delegates, disapproved actions of hospitals in predicating staff privileges upon susceptibility to pressure to make "voluntary" cash donations, and other offenses by hospitals; and called for a thorough investigation of such charges by the Medical Society and for definitive and punitive action against hospitals found guilty.

It was the opinion of the investigating committee, the Advisory Committee on Hospital Relationships, that no action can be taken, especially punitive action, against hospitals unless there are specific allegations brought forth by a group of physicians or a county society, so that legal steps may be taken. The committee suggested the desirability of establishing a test case to bring this matter to a decisive conclusion.

Hospital Care for Caesarean Sections (Reference Committee "C")

"That Hospital Service Plan of New Jersey be requested to make available hospital care for caesarean sections under the same provisions as for other abdominal surgery" was a recommendation of Reference Committee "C" in 1953 adopted by the House of Delegates.

In response to a letter from the Board communicating this action to Hospital Service Plan, it was stated that the new Subscription Contract provided for an additional two days (making a stay of 9 midnight days eligible) in eligible maternity cases involving operative surgery (as in cases of caesarean sections).

Judicial Council

(Reference Committee "A")

D. F. FEATHERSTON, M.D., Chairman, Asbury Park

DURING the past year the Judicial Council met regularly. At the state level it considered seven complaints and it supervised 45 complaints that were dealt with at county level.

With the experience of the Council since its inception in 1951, under the present regulation of the Constitution and By-Laws of The Medical Society of New Jersey, it has become apparent that the mechanism for processing the material handled is cumbersome and could be simplified easily without detracting from its efficiency. While the Council feels that it has more than justified its existence, it has been difficult to project the rapid processing of complaints to the county level and to bring them to a prompt conclusion.

The county judicial committees have seemed uninformed as to their duties, responsibilities and powers. There has also been a deficiency in that the reports of the findings of the county

judicial committees have not been forwarded to the Judicial Council.

The Council as a whole is convinced that the function of the District Council as set up in the structure of the State Constitution and By-Laws has not worked; in fact, so far as we know, it has never been used since its inception.

To obtain a cross section of opinion on the working of the judicial branch of the Society, a meeting was held March 7, 1954, at state society headquarters, at which representatives of county judicial committees and county officers, together with Mr. Gerald F. O'Mara and Mr. John F. Lynch, legal advisers, were present. The meeting confirmed the Council's opinion of the defects in the mechanism outlined above. It is recommended that an entire review of the Council's procedures be made for the purpose of suggesting changes in the Constitution and By-Laws which will increase the efficiency of the Judicial Council.

First District

Union, Warren, Morris and Essex Counties

FRANCIS C. WEBER, M.D., Councilor, Newark

THERE was no business at the district level.

The meetings of the state judicial council were attended; a report of them will be given by its chairman.

Third District

Mercer, Middlesex, Somerset and Hunterdon Counties

JACOB J. MANN, M.D., Councilor
Perth Amboy

AS COUNCILOR for the third district I wish to report that the only two cases from this district which came before the Judicial Council were referred to the proper county judicial committees and amicably settled.

Fourth District

Camden, Burlington, Ocean and Monmouth Counties

DANIEL F. FEATHERSTON, M.D., Councilor
Perth Amboy

THERE were no complaints brought to the attention of the Council from the Fourth Judicial District, no investigations made and no other business transacted.

Fifth District

Cape May, Cumberland, Atlantic, Gloucester and Salem Counties

ISAAC N. PATTERSON, M.D., Councilor
Westville

THE FIFTH District has no report for this year, although we have stood by for any calls for assistance. We are happy to report that no such calls were made upon us.

Executive Officer

(Reference Committee "A")

RICHARD I. NEVIN, Trenton

AN ANNUAL report is very much akin to the peroration of a speech; it involves a recapitulation and a final appeal—a summary appreciation of what has gone before and a series of recommendations for future action. It is indulged in the interest of unity of understanding and of effort, to insure the attainment of the ends sought. Thus, it is no mere formality of composition but an essential component of an intelligent procedure.

A profession that deals with people and their needs and desires—as medicine does so utterly—is bound to be complex and challenging. Medicine was organized to further the aspirations and to advance the good of its members; to integrate the disciplined efforts of physicians with those of other agencies—of government, education, and social service—which subserve the public welfare; and, in consequence of the foregoing, to enable doctors, with wisdom and compassion, to alleviate the sufferings and improve the health of mankind. The work of The Medical Society of New Jersey consistently reflects those three-fold objectives together with our common efforts to realize them.

ON BEHALF of the members of The Medical Society of New Jersey, the officers and the members of the Board of Trustees and of all the various committees give generously of their time and energies in determining policies and effecting programs and procedures calculated to redound to the general advantage. Only one standard of judgment prevails in the deliberations of all these various groups, "the greatest good of the greatest number of our members." That principle permeates every consideration, from the establishment and operation of our Physicians' Placement Service to the adoption of official positions concerning legislation, from the formulation of broad public health and public relations programs to the answering of individual letters that may bear upon the relationship of a single doctor and the patients whom he serves.

Apart from our work for and in behalf of our members, within the state society we constantly keep in touch with agencies of all kinds whose official areas of concern and action in

any way coincide with ours. We are in constant contact with the various departments and bureaus of the A.M.A., with the agencies and subdivisions of state and local governments, with representatives of the dental profession, the bar, the Nurses' Association, the Hospital Association, service clubs, and civic, welfare, and educational organizations. Through our public relations programs and efforts we reach the general public, directly and indirectly, in an endeavor to eliminate the frictions that embarrass and to stimulate the mutual attitudes that strengthen the position of medicine in the public regard.

ALL these varied fields of interest and action impose a heavy burden of work upon those who serve The Medical Society of New Jersey. As the Executive Officer, whose official duty it is to be familiar with and part of all the Society's endeavors, perhaps better than anyone else I can testify regarding the generous measure of service rendered. Accordingly, in the name of all the members, I hope that I may be permitted the privilege of saying a hearty "Well done!" to our retiring President, Dr. Henry B. Decker, and to all his fellow officers; to the chairman and members of the Board of Trustees; to the judicial councilors; to the members of the Welfare Committee, the liaison committees, the standing committees, the special committees, the subcommittees, and the advisory committees; and to the officers and members of component county societies who have assisted in and ably carried forward our state programs.

A special word of gratitude is due the officers and members of the Woman's Auxiliary to The Medical Society of New Jersey for their tireless and inspiring support of our efforts, and especially for the wholehearted way in which they have cooperated in our endeavors to achieve a more compact and efficient organizational structure, for the better correlation of Auxiliary activities.

FINALLY, I wish to commend the administrative secretary and our entire staff for the unusual abilities and the genial and generous

spirit that have so frequently made work a pleasure.

The problems of medicine will never all be solved, because medicine deals with life — economic and social as well as physical, now-days—and life is dynamic and ever-changing, necessitating new decisions and new adjustments. We have, however, the means of solving those problems as they confront us. The formula has worked in the past; it will not fail

in the future, unless we fail in applying it. It demands enlightened minds and compassionate, unselfish hearts, the inspiration of a worthy ideal, generosity of effort, and tireless perseverance that work intelligently and cooperatively for ends that are truly good. Thus, in the past, we have worked and have accomplished. Only by so working can we continue to savor the double sweetness of the joy of the work and the triumph of achievement.

Nominations for Emeritus Membership

(Reference Committee on Resolutions and Memorials)

THE following nominations for election to emeritus membership at the 1954 Annual Meeting have been received from the county medical societies:

Camden County—Dr. William G. Shemeley, Jr., Darby, Pa., formerly Camden; age 67; retired because of ill health; member in good standing since 1933.

Essex County—Dr. Edwin J. Kaderabek, New Smyrna Beach, Fla., formerly East Orange; age 58; retired because of ill health; member in good standing for over twenty years.

Dr. Elizabeth Brakeley, Montclair; age 60; retired from practice; member in good standing for over twenty years.

Dr. H. Garrett Vander Veer, Skaneateles, N. Y., formerly Bloomfield; age 57; retired from practice; member in good standing for over twenty years.

Dr. H. Roy Van Ness, Newark; age 68; retired because of ill health; member in good standing for over twenty years.

Morris County—Dr. George J. Young, Morristown; age 56; retired because of ill health; member in good standing for over twenty years.

Proposed Amendment to the Constitution

(Reference Committee on Constitution and By-Laws)

THE 1953 Reference Committee on Resolutions and Memorials called attention to a flaw in the requirements of the constitution regarding election of honorary members. It was suggested that honorary members be proposed one year before they are elected, so that possible opposition to such nominations may be voiced during the intervening year.

The Board of Trustees reactivated the 1953 Reference Committee on Constitution and By-Laws for the purpose of studying this matter. The following proposed amendment to the constitution was received from the study committee and was approved by the Board of Trustees, on January 10, 1954, for referral to the House of Delegates for consideration.

CONSTITUTION, ARTICLE IV, SECTION 5 — HONORARY MEMBERS

Honorary members shall be physicians and surgeons who have attained distinction within the medical profession or non-medical persons who have rendered signal service to The Medical Society of New Jersey or who have attained special eminence in scientific fields other than medicine.

Nominations shall be submitted by recognized medical groups to the Committee on Honorary Membership for approval or disapproval, and the committee's action shall be transmitted to the Board of Trustees by December first. Nominations approved by the Board of Trus-

tees shall be officially sent to the component county medical societies at least three (3) months before the annual meeting at which action is to be taken, and the approval of a majority of the component county medical societies shall be required to validate the nomination before it can be submitted to the House

of Delegates. Nominees may be elected by a two-thirds vote of the House of Delegates provided the number of living Honorary Members does not exceed fifteen (15). Presentation of the honorary membership shall be made at the following annual meeting. They shall have all the privileges of members, but shall not be members of the corporate body.

Special Committees • • •

(Reference Committee "D")

Emergency Medical Service, Civil Defense

HERSCHEL S. MURPHY, M.D., Chairman, Roselle

ON DECEMBER 6, 1953, the first meeting of the Special Committee on Emergency Medical Service, Civil Defense was held. Following the suggestion that the committee be expanded, this was done and the new enlarged committee met on March 21, 1954.

The purpose of this committee is to serve in an advisory capacity to the State Department of Health and State Division of Civil Defense and Disaster Control on any medical problems that may arise in regard to civil defense and disaster control.

The need of securing qualified leadership for the allied and auxiliary medical and health personnel has become of greater importance with the January 14, 1954, amendment of the Civil Defense Law to include natural disaster control. This committee felt that the activities of the allied and auxiliary medical and health groups—hospital administrators, dentists, veterinarians, professional and practical nurses, pharmacists, osteopaths, chiropractors, optometrists, health officers, non-official agency administrators, funeral directors, ambulance and rescue squads, and similar groups—should be integrated right from the beginning by holding a meeting once or twice a year with liaison representatives of their state organizations.

Participation of the Medical Society, through this committee, with the cooperative effort and ingenuity of these allied and auxiliary professional groups must be on a long-range basis. This must be done to insure the utiliza-

tion of the existing resources of such personnel to the best advantage so that we may provide the maximum protection and medical care to the citizens of our state under the unusual conditions of a mass disaster from enemy action or natural causes.

IF THE above suggestion is approved, we recommend that "contacts" from the state organizations of these groups be invited to meet with this committee at least once a year. They would represent a selected group through which information can be disseminated and integrated in civil defense medical programs.

This committee was asked by the New Jersey State Nurses' Association to prepare "standing orders" for the civil defense disaster and civil defense nursing corps. The members of this committee felt that "standing orders" are a matter of greater complexity for nurses of the civil disaster nursing corps than for nurses under other circumstances. In mass civil disasters, the professional medical personnel not only will have to use their own skills as effectively as possible but also will be expected to encourage members of the allied professions to enroll and receive training to perform in such emergencies many medical acts requiring less skill than major procedures.

It would appear that in connection with difficulties encountered when certain civil de-

fense and civil disaster workers, assigned in the healing arts, to practice outside of one's immediate field, the amendatory Chapter 14, P. L. 1952 would be adequate legislation to protect these workers (dentists, nurses, etc.). It appears to this committee that, in essence, this Chapter gives to the above mentioned allied and auxiliary medical professions the legal authority to attend any casualties at such a time *provided only that they are authorized and assigned to perform certain duties in stated areas*. Upon competent legal advice, this committee forwarded a request to Dr. Bergsma, Director of Civil Defense and Disaster Control Medical and Health Services, that he secure a formal opinion from the Attorney General of New Jersey as to the intent of this Chapter

14. Until this opinion is obtained, this committee feels that the standing orders cannot be completed.

IT MIGHT be proper at this time to record that at the request of Dr. Bergsma, and with the approval of Dr. Decker, President of The Medical Society of New Jersey, the function of this committee, is to act, through the Board of Trustees, in an advisory capacity to the New Jersey Division of Civil Defense and New Jersey State Department of Health. Therefore, the committee wishes to recommend the importance of the continuity of program and membership of this committee.

Medical Research

RAY E. TRUSSELL, M.D., Chairman, Flemington

THE Medical Research Committee is not intended to represent all fields of research but does act as a mechanism for bringing to the Society informed opinion regarding medical research—either announced discoveries or proposed work.

The Committee has continued to function this year in an advisory capacity and has reviewed all projects brought to its attention for such action. The following points summarize the year's activities.

Rheumatic Fever Control Project—A joint meeting of the Subcommittee on Public Health and the Medical Research Committee was held on October 29, 1953. Chairmen of the Advisory Committees on Cardiovascular Diseases, Child Health and School Health were invited to attend. Dr. Harrold Murray acted as chairman for the meeting.

The group considered the research evidence for the control of rheumatic fever and heart disease through early and adequate treatment of streptococcal infections and through prophylactic treatment of individuals known to have had rheumatic fever. There is a considerable body of carefully collected evidence that the incidence of rheumatic fever can be reduced by such measures which are clearly the opportunity and responsibility of the practicing medical profession.

The meeting also concerned itself with the

recommendations of the Council on Rheumatic Fever and Congenital Heart Disease of the American Heart Association for the control of rheumatic fever and a proposal for its county-wide application in Hunterdon County.

The project has the formal approval of the Hunterdon County Medical Society and is co-sponsored by the Hunterdon County Heart Association, Hunterdon Medical Center and the Bureau of Heart Disease Control, State Department of Health.

In brief, for a period of at least two years an intensive county-wide effort will be made by physicians to treat streptococcal infections early and adequately (usually with penicillin) and to maintain known rheumatics on prophylaxis (usually with sulfadiazine). Public health and school nurses and teachers will alert parents to the need for such treatment and will follow up to ascertain the degree of cooperation. An evaluation program for known or suspected cases of rheumatic heart disease will be maintained at the Hunterdon Medical Center on a referral basis. Drugs for indigents will be available through a grant-in-aid from the State Health Department. The determination of need for such drugs is made by the family physician.

Since this is an exploratory project limited to one county no formal request for approval

was believed indicated at this time and the project has been initiated with the understanding that it should be reviewed on behalf of the Society in two years for determination as to whether such a program should be sponsored on a state-wide basis.

Poliomyelitis Vaccine Field Trial — At the request of Commissioner Bergsma, a joint meeting of the Medical Research Committee and the Public Health Committee, also attended by chairmen of the Child Health and School Health Committees, was held on February 9.

The purpose of the meeting was to review some of the research background for and the practical problems revolving around the field trial of poliomyelitis vaccine proposed for next summer.

After thorough discussion of the project, it was agreed that the group approves in principle participation in the field trial of polio vaccine in New Jersey on the condition that the developments will be watched from point to point and that if at any time there is evidence of dangerous effect of the vaccine, the New Jersey State Health Department will

withdraw from further participation in the field trial until the situation can be re-evaluated.

The foregoing recommendation was submitted jointly with the Public Health Committee to the Board of Trustees for consideration and necessary action.

Miscellaneous — The chairman of the Medical Research Committee has made advice available to one hospital which requested information on the administrative basis for accepting and handling research grants. Information has also been requested from the Committee on Research of the Council on Pharmacy and Chemistry regarding their activities which might be applicable in New Jersey. The Committee has also received a preliminary communication regarding a lung cancer project under consideration in the state.

Committee Membership—Dr. Daniel Bergsma, Dr. Samuel Blaugrund, Dr. Lewis Coriell and Dr. W. Alan Wright have been members of the Committee this year. Dr. Walton Van Winkle and Mr. J. Harold Johnson have served as consultants.

Medical School

STUART Z. HAWKES, M.D., Chairman, Newark

DURING the past year the Medical School Committee has had a very active program not only within our own society and in co-operation with the Dental Society, but also with the Citizens Committee and representatives of the state government.

There have been five stated meetings of our committee at which chairmen of the Public Relations Committee and the Legislative Committee have been in attendance as well as the majority of the officers of the Society and the executive officer. In this way a coordinated program has been carried out with the Public Relations and the Legislative Committees.

All the proposals of the Medical School Committee have been submitted to the Board of Trustees for approval before any implementation has been carried out. Important parts of the program which they have approved are these:

- 1.) Renewal of the contract of our public relations counsel on an annual retainer fee.
- 2.) Placing in the hands of our public relations counsel all procedures pertaining to

public relations so that he may assume responsibility for the preparation and release of items intended for newspaper, radio, and television presentation, and coordinate activities with the Citizens Committee. All of these functions are being performed by Mr. Milford subject to the approval of the chairman of our Society's Public Relations Subcommittee.

3. The reaffirmation on the part of Mrs. Mary G. Roebeling of Trenton, as chairman of the Citizens Committee, of her intent to develop a program to stimulate public support. Numerous conferences have been held with Mrs. Roebeling and her staff.

4.) The development of a time schedule of public relations activities to inform the public on the need for a medical school.

5.) Assistance in development of a legislative program to prepare legislation for submission during this session of the Legislature.

6.) A meeting with Governor Meyner and his aides to explore the various aspects of the problem.

IN FEBRUARY, a conference was held under the auspices of General Johnson, at which prominent medical and dental educators, representatives from the state government, legal representatives of the Medical and Dental Societies, and officers and many members from both societies were present. This day-long conference considered the medical-dental school and health center project as a whole. The conferees considered this meeting very constructive as it brought out many of the problems,

and also brought together some of those responsible for their solution.

At present the Governor recommends the introduction of legislation during the current session calling for a referendum on the ballot in November 1954. It is felt that the legislation should be bipartisan. Once this legislation has been enacted, the campaign to tell the story to the entire electorate of the state should be launched.

Physicians Placement Service

(Reference Committee "D")

MARCUS H. GREIFINGER, M.D., Chairman, Newark

DURING this year the number of physicians registering with the Physicians Placement Service increased steadily and the number of listings of communities in need of additional physicians slightly decreased.

More and more, physicians within the state looking for an assistant or associate are turning to the facilities of the Placement Service for aid. Contact has also been made with the secretary of the New Jersey Society of Clinical Pathologists and we are now able to refer registrants desiring to specialize in this branch of medicine to a proper source for guidance.

Up to the present time we have had a limited knowledge of industrial opportunities for physicians, although many registrants have indicated their interest in this field. During the coming year the Physicians Placement Service hopes to expand its activities in this area.

The records indicate that during 1953-54 placements were made both in communities and in medical groups. We also made available

to a community in Virginia our list of registrants. In acknowledging the information received, the secretary of the civic committee stated, "In all our contacts we have found that your office has the most complete and up-to-date information of any placement service."

DURING the past year we listed 66 communities in need of physicians. At the present time 19 have been dropped, their need for additional physicians having been filled. A total of 157 physicians registered with the placement service. Of these, 84 found a suitable location and were dropped from our list. (31 are practicing in New Jersey.)

At the present time our records indicate 47 communities still need additional physicians, 6 members of the Society are looking for assistants or associates, a few industrial vacancies are yet to be filled, and 73 physicians are still registered with the Physicians Placement Service.

Finance and Budget

(Reference Committee "B")

DAVID B. ALLMAN, M.D., Chairman, Atlantic City

ANY report of the Committee on Finance and

Budget prepared for publication in advance of the convention must be tentative and general in character. Only after completion of the fiscal year does it become possible to speak in

precise terms of the year's finances.

From our point of view this has been a sound and satisfactory year, as we expect to demonstrate when the final budget is submitted for approval at the annual meeting.

Publication

(Reference Committee "B")

J. LAWRENCE EVANS, JR., M.D., Chairman, Leonia

NINETEEN Fifty-three was of special significance for the JOURNAL, which could proudly look back upon fifty years of life as a publication.

The occasion was memorialized in the "Fiftieth Anniversary Issue" published in September. The several eminent reviews of medical progress in our state included in this issue are a source of satisfaction and a stimulus for the future.

During 1953, Dr. Rowland D. Goodman, 2d was appointed editor, following his most capable completion of six months as acting editor. In May 1953, Dr. Henry A. Davidson, for so long a mainstay of the JOURNAL, resigned as editorial consultant to devote his full time to present duties.

The year saw additions to JOURNAL content. A "Letters to the JOURNAL" department was reinstituted. Small items of interest and announcements, previously scattered throughout the JOURNAL, were published on an added "Announcements" page.

In November, internal changes in layout and typography were authorized by the Publication Committee, which became effective with the January 1954 issue. The nature and

proportionate content of the JOURNAL continued to be predicated upon the majority opinion expressed in a canvass of the general members of our Society.

Despite ever-increasing costs of publication, your JOURNAL continues to operate successfully at no cost to the Society beyond the one dollar allotted from the annual dues of each member. The energetic and progressive work of our advertising representatives has contributed much to this financial aspect of publication.

The Publication Committee expresses its appreciation to Dr. Goodman, whose enthusiasm and ability have been apparent during his first year as editor. Mrs. Miriam Armstrong, our indispensable assistant editor, has added another notable year to her already impressive record in the management of JOURNAL operations. Mrs. Edith L. Madden has continued her efficient work in the correlations between the JOURNAL and the Executive Offices.

Your Publication Committee solicits for the coming year the comments and advice of the members of our Society. It is our desire, guided by your expressions, to publish the JOURNAL according to your wishes.

Annual Meeting

(Reference Committee on Miscellaneous Business)

JEROME G. KAUFMAN, M.D., Chairman, Newark

THE schedule for the 1954 annual meeting follows the format of last year with the exception of the scientific sessions. The latter have been planned in accordance with the action of the 1953 House of Delegates:

1. Three general sessions will be held in the afternoons from 2:00 to 5:00 p.m. on Monday, Tuesday, and Wednesday—one session on medicine, one on surgery, and one on pediatrics, obstetrics and gynecology—the programs of these general sessions to be subjects of wide appeal.
2. The mornings of Monday and Wednesday will be devoted to individual section meetings of the remaining fifteen sections; these fifteen sections will be privileged to meet every year if they so desire.

The committee and the section officers met last September to review proposed section programs and formulate the daily schedule. The officers of the Section on Pediatrics requested that they be permitted to hold a morning session, in addition to participating in the afternoon general session. They felt that unless a separate session of their own were scheduled, the attendance of pediatricians would be inadequate. It was the consensus of the group that permission be granted.

THE Section on Pediatrics requested that it be divorced from the general session on pediatrics, obstetrics and gynecology. It was the general feeling that for this year the program should follow the outline adopted by the House of Delegates. It is the recommendation of the committee, however, that hereafter the general afternoon sessions be on medicine, surgery, obstetrics and gynecology, and that pediatrics be included only in the morning section meetings.

The sections on cardiovascular diseases, chest diseases, radiology, and urology indicated that they would not meet in 1954.

It was stressed again to the section officers that the Society's policy is that all section programs should be planned for the interest of the general membership and not primarily for the interest of the specialty groups. The committee each year emphasizes this point, since

it is the inclination of the sections to prepare their programs for the interest of the members of their own specialty without thought to the majority membership of the State Society who are not affiliated with any specialty society.

FOR the three general afternoon sessions the committee ruled that each would be permitted up to three out-of-state speakers whose expenses would be paid by the Society, travel and overnight at the hotel. The sessions were requested to try to keep their expenses under \$300.00 each.

It was felt by some section officers that the ruling of allowing only one out-of-state speaker per morning session was too restrictive; that in consequence panels could not be used, nor did the sections have enough leeway in choice of speakers on specialized subjects. The committee pointed out that the limiting of sections to one out-of-state speaker provides a forum for New Jersey physicians to present papers, and that the matter of expense also must be kept in mind. It was the final action of the group that all morning section meetings would, insofar as possible, hold to one out-of-state speaker but that expenses would positively be limited to not more than \$100 per section.

It was commented that some sections find it difficult to find member speakers who have papers for presentation at annual meetings. The suggestion was made that an item be carried in the Newsletter or JOURNAL requesting those members who want to present papers at section meetings to contact the respective section officers during the summer or early fall.

FINAL section programs were requested by December 1, 1953. Shortly after that date the "steering committee," composed of the chairman of the Annual Meeting Committee, chairman and co-chairman of the Scientific Program Committee and the president met to review the programs.

We were amazed to find so many of the programs out of line with the procedures adopted at the September meeting. One morning session listed four out-of-state speakers

with no papers by New Jersey members. Three sections listed papers on the same subject, another section listed papers totally unrelated to their proper program, and others listed out-of-state discussers. It had been planned to publish the advance program the first week in January, however, the necessity of writing letters and getting the officers to bring their programs into line took considerable time, which delayed the program publication and mailing to the end of January.

The steering committee felt the problem warranted action by the Board of Trustees, and on January 10, 1954, the chairman of the Scientific Program Committee asked the Board if the policy of the society regarding out-of-state speakers for section meetings was to be altered, or was the committee to hold to the present policy and reject section programs that did not adhere to this policy. It was the decision of the Board that the committee allow sections to invite one or two out-of-state speakers, as determined by the circumstances and at the discretion of the section chairmen, but that the number is not to exceed two for any section. The Board directed that since the 1954 programs were complete they be carried out, and that the above action would be effective beginning with the 1955 annual meeting.

IN DISCUSSING the scientific exhibits, the steering committee felt that the expense per exhibit was mounting each year and that a measure of economy should be effected. It was felt that some exhibits could do with less space, thereby accommodating more exhibits. It is the recommendation of the committee that scientific booth space be laid out in backwall lengths of 8, 10, and 12 feet; that the floor plan be drawn up in advance accordingly; and

that prospective exhibitors be offered space in these measurements, rather than that the floor plan be laid out in accordance with the space requested by exhibitors.

The technical exhibits have been increased by thirteen booth spaces for 1954. All space was reserved within a month of contacting prospective exhibitors, and even with the additional space several companies have had to be turned down.

Each year the Medical Exhibitors Association makes a rating on the convention from the viewpoint of some exhibitors who are members of the association. The rating does not represent the views of all exhibitors. This year the committee intends to conduct its own survey among the technical exhibitors in an effort to get their viewpoints on various points. The survey findings will be studied carefully and taken into consideration in planning the 1955 exhibits.

WITH the additional income from the technical exhibits this year, the committee is hopeful of meeting the convention expenses without having to draw on its reserve account. The past two years have shown a deficit and reserve funds have had to be used to meet extra expenses. The reserve account was built up over a period of years when receipts were higher than expenses and the committee appreciates this reserve when the reverse is true. Since 1939 the committee has not had to ask the Society for any monies to operate the annual meetings.

The advance program, mailed to the membership in January, has been received with favorable comment. We are looking forward to a most successful meeting and a very large attendance.

Scientific Exhibit

(Reference Committee on Miscellaneous Business)

ASHER YAGUDA, M.D., Chairman, Newark

THE Scientific Exhibit Committee has accepted applications for twenty-seven outstanding exhibits for the annual meeting of 1954. A number of applications had to be rejected because of lack of space. It was also necessary to cut down the space allotment of many of the applicants. As far as possible the

exhibits have been arranged in sections so that related exhibits will be grouped.

We are sure that careful study of these exhibits will be of great help to the doctors of New Jersey in acquainting them with the latest scientific work in the fields concerned.

Scientific Program

(Reference Committee on Miscellaneous Business)

JOHANNES F. PESSEL, M.D., Chairman, Trenton

MANY opinions have been expressed about the "ideal annual program." Every section seems to agree that the best program is the one that would appeal to the greatest number of members of the Society. In spite of this, it has become increasingly difficult to convince some sections that the meeting is for the entire Society and not for the specialties alone. Some of the programs submitted this year were completely filled with foreign (extra-state) talent. In the past this has not always guaranteed a full attendance at the meeting even though the speaker was an outstanding national figure. As some formula had to be arrived at, we requested a ruling from the Board of Trustees. We obtained the following: "Each section shall limit itself to two out-of-

state speakers. No section shall expend more than \$100 for the expenses of their speakers."

Upon receiving this ruling, we arranged this year's program within the sphere of this directive and attempted to the best of our ability to satisfy all specialties. It seems essential and necessary that some regulations for all divisions be established and adhered to. Unless some formula is set up for future programs, only dissatisfaction will ensue.

We believe this year's scientific program will be interesting, timely, and instructive. It is our hope that all section members will attend their meetings and give the essayist their whole-hearted support. It will encourage him and make for a much better program.

Advisory to Woman's Auxiliary

(Reference Committee on Miscellaneous Business)

LEWIS C. FRITTS, M.D., Chairman, Somerville

SEVERAL conferences have been held during the year between officers of the Society and the Auxiliary in order to achieve unity of purpose and action. Reports of these conferences were made to the Board of Trustees, and the Board took occasion to express its appreciation of the many splendid accomplishments of the Auxiliary in the past and of its generous support of the undertakings of the state medical society. The Trustees stressed one point: The Woman's Auxiliary will be able best to assist The Medical Society of New Jersey in the realization of its goals only when all the Auxiliary's programs and procedures are fully in accord with the programs and procedures officially adopted by the state society. Through complete identification of aims and

close cooperation of efforts, the state society and its auxiliary will work most harmoniously and profitably together.

The Auxiliary officers, with customary graciousness, accepted this as a point of instruction and immediately set about to bring their plans and programs into line. Considerable progress has been made this year toward the ultimate goal of complete coordination, and it is expected that next year will see its realization.

The Woman's Auxiliary is always a ready medium of assistance to the Medical Society. The willingness of the ladies has been well proved, and their continued efforts in our behalf are deeply appreciated.

Honorary Membership

(Reference Committee on Resolutions and Memorials)

ALDRICH C. CROWE, M.D., Chairman, Ocean City

NO NAMES have been submitted to the committee in nomination for honorary membership in The Medical Society of New Jersey. Therefore, it has not been necessary for the committee to meet this year. As chairman, I am in complete accord with the proposed

amendment to the constitution, as approved by the Board of Trustees. This amendment will require approval of the nominee by county medical societies before the nomination is brought before the House of Delegates.

Welfare

(Reference Committee "E")

ISAAC N. PATTERSON, M.D., Chairman, Westville

THE Welfare Committee met at the headquarters of the State Society on September 27, 1953, with an attendance of 51—39 of whom were members. On October 25, 1953, the Board of Trustees approved the reports with few exceptions. These reports defined the programs of the subcommittees and advisory committees for 1953-54.

On December 6, 1953, the Welfare Committee again met in Trenton. The progress report of the Legislative Committee stated that bills were being prepared to bring the optometrists engaged by local boards of education under the direction of the school physicians, to amend the Society's charter to permit the investment of surplus funds, to establish a medical-dental school, and to regulate post-

mortem examinations. The Subcommittee on Medical Practice reported progress on its study of criteria for medical specialists. The Public Health Subcommittee reported progress in the problem of screening examinations.

At the December meeting the relationship between medicine and osteopathy was considered. The committee directed that the subject be taken to the county level, discussed by each component society and reported upon at the next meeting in March.

On March 21, the final meeting of the year was held, a report of which was presented to the Trustees on April 4, for their consideration. At this meeting, the annual reports of the subcommittees were approved.

(Reference Committee "E")

Legislation

C. BYRON BLAISDELL, M.D., Chairman, Asbury Park

THE committee was saddened when death claimed two of its members this year. Dr. Adolph Wegrocki died on September 27, 1953. His passing deprived the subcommittee and the Society not only of the services of a distinguished and conscientious physician, but of a man whose years of experience as a member of the State Legislature enabled him to advise and counsel his fellow members of the subcommittee in their task of evaluating proposed legislation. Dr. Joseph F. Londrigan died on October 17, 1953. He served the committee and the Society diligently for years, and his place as Executive Secretary to the subcommittee is one which cannot easily be filled. Inasmuch as the bulk of the legislative work comes during a limited period of the year—chiefly from November until May—and since there has been decentralization of the legislative contact activities, which are now referred to the keymen in the counties, it seemed unnecessary at the time to attempt to fill the vacancy.

The committee was later informed that a special committee of the Board of Trustees had recommended that the legislative committee carry on its work this year through the Executive Offices, that bulletins and information be disseminated through the counties and through the keymen; and that this working arrangement be tried out and examined later. The appointment of a successor to Dr. Londrigan was therefore postponed indefinitely, and the need for a successor will be evaluated after full reports are in on this legislative session.

RECEPTIONS FOR LEGISLATORS

IN THE interests of better understanding with the members of the Assembly and Senate, two receptions were held this year—one for newly elected legislators, and the other for the entire membership of the two chambers. Governor Meyner honored us with his presence at the first, held at the end of January.

We attempted, with the keymen present and other members of the Society, to give the new men in the Legislature a good time and to assure them of our interest in their problems. The second reception was held on March 22. Its popularity may well be attested by the attendance—of the 79 members of the Senate and Assembly invited, 65 were present; in addition many of their secretaries accompanied them.

In the opinion of the committee these meetings, which provide an opportunity for the senators and assemblymen to meet with doctors whom they know from their own counties, have markedly improved our position with the legislators. Evidence of their goodwill and their readiness to listen to our opinions and to introduce our legislation have been apparent at these meetings. It is the opinion of the committee that we have made considerable advance in the favorable relationship we have with them.

STATE LEGISLATION

TWO of the four bills authorized for preparation and introduction by the Legislative Committee have been submitted to the Legislature and are at this time awaiting action. These are the bills on amendment to the charter and on post-mortem examinations.

The bill to place optometrists under the direction of the school physician is in the hands of the Legislature but has had, at this writing, no number assigned to it. The bill for the medical-dental school and health center referendum and bond issue has been recommended by both the Legislative Committee and the Welfare Committee to the Board of Trustees. The future of the bill will rest upon the decision of the Board as to when such a bill will be introduced. It is understood that Governor Meyner feels that some delay is advisable at this time since there are possibilities of getting private funds in behalf of the undertaking, which might make the amount of the bond issue less formidable.

No action by the Assembly and Senate has yet been taken on many of the bills in which the Legislative Committee has an interest. It is expected that a bill to license nurses will cause much opposition on the part of the New Jersey Hospital Association, but the committee has approved the purpose of the bill and its method of licensure—informing the nurses, however, that the Society would look with disfavor on any effect which would limit the number of nurses available to the public because of stiffened requirements or restrictions, and also with disfavor on any interpretation of the bill which would make utilization of orderlies, ward helpers, technicians, et cetera, in any way more limited for the hospitals. It is recognized by the committee that emergency conditions could arise under which a hospital would have to delegate certain services to personnel not routinely performing such services.

OTHER bills bearing on air pollution, potable water supplies, garbage disposal, a drunken driver test, care of narcotic addicts, et cetera, have been reviewed by the committee and approved, disapproved, or have had no action taken on them according to the committee's interpretation of the Society's attitude toward the subjects involved.

In studying the various bills the committee has adhered to its principle of conferring with the Medical Practice and Public Health Committees and other interested subcommittees or advisory committees for their advice and aid in interpreting and deciding upon the merits of such bills. Their cooperation has been much appreciated.

The *national scene* has been very hectic this year, and a new attitude by the A.M.A. toward the administration has been slowly evolving.

The Medical Society went along with the A.M.A. in supporting the Bricker amendment in principle and only insofar as it might affect medicine or advance the socialization thereof. The A.M.A. position with respect to public health grants-in-aid, to extension of the Hill-Burton Construction Act, and to the President's hospitalization reinsurance program has not yet been determined. This committee therefore has been unable to take a position on these, chiefly because of insufficient information.

A NEW system for activating state legislative committees, at the behest of the A.M.A., has been evolved by Dr. David B. Allman, Chairman of the A.M.A. Committee on Legislation, and accepted by our Society. Keymen for each of the states' congressional districts have been organized under a plan whereby information and direction for action on given bills may be quickly furnished and advice to their congressional representatives promptly initiated.

A large number of the committee members attended a regional conference of the A.M.A. in New York with respect to national legislation. This meeting was very informative. It is felt that the work of the A.M.A. Legislative Committee through its secretary, Mr. C. Joseph Stetler, is very well handled and that the Washington News Letters are more informative and helpful than in the past.

As in past years this committee is limited to summarizing the year's work up to the date of this report because of the continuation of the legislative session. The supplementary report, to be offered to the House of Delegates at the opening session, will bring the Society up to date on the status of legislation in New Jersey and Washington.

Medical Practice

RUDOLPH C. SCHRETZMANN, M.D., Chairman, West Englewood

THE Committee on Medical Practice met three times during the year at the headquarters in Trenton.

The following are the items which were presented for discussion and action by the committee.

The Use of Drugs by Chiropractors: Several complaints were received which stated that chiropractors were using drugs which exerted a strong systemic effect. According to the Attorney General's interpretation of the law, chiropractors are allowed to use any thera-

peutic agent in any fashion if it is "especially directed to and necessary for the treatment of a disease of the foot."

The Committee on Medical Practice felt that drugs having a systemic effect should not be used by a practitioner with a limited license who is not fully licensed to practice medicine and surgery. Probably a revision of the existing law is in order so that therapy could be defined more specifically.

Medical Practice by Clinical Psychologists was brought to our attention by some neuropsychiatrists who complained that there is evidence that psychologists are attempting to treat conditions which are classified as diseases of the mind. Our committee recognized the importance of the psychologist in testing individuals within the scope of his field but that mental illness should only be treated by qualified neuropsychiatrists. Medical practice acts are not clearly written on this subject because as of now, there is no clear definition of psychology. Until that is arrived at, it will be difficult to restrict legally the professional activity of psychologists.

It was felt by this committee that the clinical psychologist can aid the psychiatrist in treating patients under his supervision; that a clear definition of a psychologist should be drawn and that his activities should be confined to the latitudes prescribed by that definition.

Developing Criteria for Specialist Consultants — The Medical-Surgical Plan has found it necessary to remove consultation fees from its schedule of benefits. This decision was greeted with mixed reactions on the part of members of the medical profession. The House of Delegates suggested that, if possible, the consultant's fee should be restored to the schedule of benefits and that The Medical Society of New Jersey should establish a list of qualifying criteria which would define adequately a "consultant."

The Board of Trustees directed the Medical Practice Committee to study the problem and suggest a solution, if possible.

The committee undertook the study of this problem with enthusiasm and spent many hours considering it.

It was recognized that the criteria adopted must include all the physicians qualified to give consultations regardless of formal certification by some accredited body. There are many such doctors who, though well qualified, are not so officially labeled.

It was felt also that the approved hospital had to be broadly defined so that no qualified staff member would be denied his rights.

After a great deal of discussion and thought, five points of criteria were adopted and sent to the Board of Trustees for its consideration.

Coroners Law Revocation was requested in a communication from the National Municipal League. The Board of Trustees requested the Medical Practice Committee to study the issue.

We recognized the antiquity and worthlessness of the coroner system and advocated that, in those few counties where the system still operated, the coroner be replaced by a qualified medical examiner.

Examination of Motor Vehicle Drivers in New Jersey. Through the Board of Trustees the Commissioner of Motor Vehicles requested cooperation of the State Medical Society in devising a plan for re-examination of drivers, to determine whether there are any who do not possess the physical or mental qualifications necessary for the safe operation of motor vehicles.

After a conference with Commissioner Darden and his assistant, and after much discussion, the committee concluded that the present law regarding motor vehicle licensure — Title 39, Chapter 3, Sections 10 and 11 — is adequate and that further legislation is not necessary.

However, a loophole in the law exists and must be closed. The committee is completely in accord with the Commissioner's plans to protect those on the highways; and will provide him with every possible assistance. It is hoped that the Commissioner will draft a plan and present it to the committee for consideration. No new plan should impose a legal burden on the physicians.

A resolution from the New Jersey Pharmaceutical Association, requesting the Medical Society's cooperation against unethical conduct by pharmacists, was sent to the committee for study.

The committee was in sympathy with the principle embodied in the resolution but could not agree that the Medical Society should police the pharmacists. It was felt that this important and highly controversial matter should be settled at some future date, after study by the Medical-Pharmaceutical Liaison Committee.

Commission on Blood Banks. A communication from the chairman of the Blood Bank Committee of the New Jersey Society of Clinical Pathologists outlined the proposed program of the Commission on Blood Banks.

It was noted that the Commission was composed of eight members chosen by the New Jersey Society of Clinical Pathologists and

two members of The Medical Society of New Jersey. A question of the legal responsibility of the Commission was raised:

The paucity of representation on the Commission by The Medical Society of New Jersey was noted, and the matter was referred to the Advisory Committee on Laboratory Medicine for study.

Hospital Service Plan (Blue Cross) Contract was criticized by the New Jersey Society of Anesthesiologists and the New Jersey Society of Clinical Pathologists for advertising payments for anesthesia and laboratory procedures in their contracts.

The committee agreed that the hospitals should not be allowed to practice medicine. But, the solution rests with the anesthesiologists and pathologists who enter into contracts with the hospitals. The insurance companies pay only for the services ordinarily rendered by the hospitals who cooperate with the plans.

The Committee on Medical Practice asked that a spokesman for the specialty groups involved meet with the Medical Society committee and try to come to some definite solution of this important problem.

Nursing Problems in New Jersey Hospitals were outlined before the Welfare Committee by the president of the New Jersey Nurses Association. It was suggested that the matter

be studied by the Committee on Medical Practice in order that, if possible, help might be given to the nursing profession in the solution of this problem.

Because of the legislative problems which now confront both the medical and nursing professions it was decided that concentrated study of this problem should be recommended to next year's Committee on Medical Practice.

Consolidation of the Advisory Committee on Physical Medicine and the Advisory Committee on Rehabilitation was urged because of the overlapping duties of the two committees and the lack of coordination between them. It was felt that if the two bodies were combined they could function more efficiently and intelligently.

The Committee on Medical Practice recommended that the committees be combined, and that the title of the new committee contain reference to both physical medicine and rehabilitation.

A resolution calling for corrective and punitive action against improper hospital practices was referred to the proper advisory committee for study.

Problems concerning workmen's compensation hearings, ethics and fees were studied and referred to the Advisory Committee on Workmen's Compensation. The report of that committee proposes means of solution.

Public Health

KENNETH E. GARDNER, M.D., Chairman, Bloomfield

DURING the past year, through an excellent spirit of interest and cooperation, the advisory committees to the Subcommittee on Public Health have studied many health problems which are of special concern to the profession and the public. Their recommendations have been reviewed and approved by the Subcommittee on Public Health, the Welfare Committee and the Board of Trustees.

One of our best public relations assets is to be aware of public health needs and advances and one of the most important functions of The Medical Society of New Jersey is, through medical articles and educational programs, to make constructive recommendations to the physicians and citizens of our state on

public health matters. The Subcommittee on Public Health has enjoyed a most cordial relationship with the members of the State Department of Health. Through the combined efforts of these two organizations the best health interests of the people of New Jersey are being protected and served.

One of our most important problems is that of chronic illness. As part of our contribution the Subcommittee on Public Health has nearly completed a recommended procedure for a yearly routine health maintenance screening program. This program is planned so that it can be carried out in the private physician's office or in conjunction with other cooperating physicians. The plan should be ready for operation in the fall.

THE prevention of disease is equally important, if not more important, than the treatment of disease. In the field of public health, prevention is the keynote for the individual as well as the community. For those diseases which cannot be prevented at present, early detection is the next most desirable accomplishment. The slogan "Early Discovery Means Early Recovery" illustrates the main purpose of the yearly routine health maintenance screening program.

In the field of prevention, the development of a vaccine against poliomyelitis is most encouraging. The Medical Society of New Jersey has been requested by the State Department of Health to cooperate in conducting a pilot study for this program. Bergen, Cape May, Monmouth, Morris and Warren Counties have been selected by the National Foundation for Infantile Paralysis for participation in the 1954 tests. The vaccine will be offered to all second grade children, since this age group has the highest incidence of poliomyelitis, with the first and third grade children acting as control groups. Permission must be secured from the parents of each child. The preliminary reports on the safety of the vaccine are most

reassuring, but it will be the responsibility of the State Department of Health, The Medical Society of New Jersey, and every physician who participates in this program to be constantly alert to untoward reactions.

ONE of the important functions of the Subcommittee on Public Health is to arrange joint conferences among various advisory groups to study a common problem. Of general public interest is the type and extent of school health examinations. As presently conducted, the school health examination is a simplified form of routine health maintenance examination, but because of its limitations and variations, it is subject to much misunderstanding and misinterpretation by both physicians and parents. This is one of the problems which is under discussion by a joint conference of our Advisory Committees on School Health, Child Health, Rural-Community Health, and Conservation of Vision and Hearing. Their recommendations should help clarify this important problem.

Public Relations

FRANK S. FORTE, M.D., Chairman, Newark

THE Subcommittee on Public Relations has completed a most gratifying year. The scope of its work has broadened materially as has the experience of its members. Thanks to the foresight of our president, the policy of membership continuity in this committee has proved valuable.

It is an inescapable fact that a large part of our Society's business involves dealing with the public. It follows most naturally that the manner in which our views are presented is of prime importance. However, just presenting views is wholly insufficient. There must be a constant awareness of individual responsibility for "good" public relations.

This year it was the committee's aim to bring to the attention of our society's membership the ever pressing problem of emergency medical coverage, the mishandling of which leads only to reproachment, public relations-wise.

On September 13, 1953, in our Trenton

headquarters, the subcommittee held its first of many meetings for the 1953-54 season. It was decided to continue all the public relations publications and procedures of last year.

MEMBERSHIP GUIDE BOOKLET

THE committee agreed to carry on the work of preparing the membership guide booklet. It was felt that until the A.M.A. had issued its revised Code of Ethics, currently in preparation, the committee in charge could work toward the completion of the booklet, to which the new code would be added.

EMERGENCY MEDICAL COVERAGE

IT WAS pointed out by Dr. Lance and Mr. Nevin that the outstanding complaint voiced by the public against the profession, as disclosed in a survey sponsored by the State So-

ciety recently, was that doctors are not available when needed. The subcommittee was unanimous in the opinion that something should be done in an organized way to eliminate this recurrent complaint. Out of this conviction grew our three-fold program for the establishment and maintenance of a functionally adequate system of emergency medical coverage in every county.

The matter of emergency medical coverage is so important that we are incorporating into this report the highlights of the plan devised.

PROJECT COVERAGE

THE program for providing emergency medical coverage for each county consists of three phases: evaluation, reconstruction, and education.

The first step in formulating such a program consists in evaluating the problem in each locality. To help the county medical societies estimate the size of the problem in their communities the following criteria may be applied:

If a present system exists, are individual doctors assigned to coverage on a definite schedule? Or is coverage provided by a haphazard general list of those willing to take emergency calls?

Is the number of doctors actively participating sufficient?

Is there a definite central agency to assign emergency calls impartially and with a minimum delay?

Has the emergency coverage system been adequately publicized?

In evaluating an emergency medical coverage program the complaints of both physicians and the public should be heeded and any constructive suggestions incorporated in the plan for improvement.

IT is further suggested that organization and planning meetings be held with the county society public relations committee and any other officers of the society whose assistance is required. The woman's auxiliary should take part and opinions of participating and non-participating physicians invited. Representatives of the public deserve to be heard and the good and bad points of any existing system should be evaluated critically.

The second phase, entitled reconstruction, consists in establishing an emergency system operated either by individual doctors or organized groups. Needless to say, where individual doctors assume the responsibility for emergency coverage it is essential that the

physician covering the absent doctor take his responsibility seriously.

Where systems are operated by organized groups definite schedules of duty assignments should be made and a method devised so that if the participating physician is unable to fulfill his assignment he can obtain a substitute.

It is also suggested that when the physician has made an emergency call he report to the central exchange and indicate whether or not the call was justified, in his opinion. If necessary, arrangements may be made with local police officials so that in uncertain neighborhoods a policeman may be dispatched to the site of the emergency calls.

The last phase of this program calls for education.

ALL physicians in the county must be completely familiar with the details of the system. They should be educated to take their own night calls and should understand that the emergency system is not an accommodation for a physician who prefers not to take night calls but a service to people when their regular physician is not available or when they need medical care in an emergency.

Each participating physician must realize his responsibility and honor such emergency calls as he may receive. He should agree to accept the uniform fee established for the county and should be encouraged to submit constructive suggestions.

The public should be educated by the local press and radio as to the existence of the emergency call system and its operation. This educational program should be carried via the county public relations committees to grammar school and high school students. Telephone numbers of the exchanges to be called in emergencies should be listed in the classified advertising section of the telephone directory and should be posted in all physicians' waiting rooms and offices and at all drug stores.

Finally every family should be urged to have a family physician. This can be encouraged by welcome wagons, service clubs, civic, social and church organizations.

PUBLICATIONS

MR. NEVIN reported that a survey on the use of our *Health Hints* by the daily and weekly newspapers disclosed that they are very well received. The Subcommittee on Public Relations officially commended the Executive Officer for his efforts in editing the *Health Hints* on behalf of the committee, and ap-

proved continuance of their fortnightly issuance.

Our *Junior Health Hints* pose a problem because of the increasing demand for them in the schools throughout the state.

The *Membership News Letter* has shown a healthy growth but our editor would welcome more contributions to its columns.

It has been recommended that our *Quarterly News Letter*, sent to cooperating agencies, be henceforth known as a "Periodic News Letter" since it is no longer necessary to publish this letter quarterly. However, it is desirable to maintain it for special purposes.

MEDICAL SCHOOL

YOUR chairman attended several meetings on the medical school project as a representa-

tive of the Subcommittee on Public Relations.

On February 28 the subcommittee attended at the invitation of Dr. Decker, the meeting of representatives of The Medical Society of New Jersey, The New Jersey State Dental Society, and the Citizens Committee for the Medical-Dental School at the State Society headquarters.

The material considered at this joint meeting, pertinent to our public relations interests, was the question of publicity for the project. The committee agreed with the policy that all medical school publicity was to be substantially withheld until a suitable piece of legislation was introduced.

We are indebted to the Woman's Auxiliary for their past help and continuing assistance in the furtherance of our public relations objectives and programs.

Public Health Advisory Committees • • •

(Reference Committee "E")

Cancer Control

H. WESLEY JACK, M.D., Chairman, Camden

THE Cancer Committee held regular sessions during the past year in conjunction with the Medical Committee of the American Cancer Society, New Jersey Division, Inc. The purpose of these meetings is to direct the cancer control program throughout New Jersey, which is financially supported by the American Cancer Society. During the past year this committee received and screened 173 projects for various phases of the American Cancer Society program in the 21 county chapters. The dollar value of these projects is \$267,985.62.

The total number of cancer clinics subsidized by the New Jersey Division of American Cancer Society during the past year was 39. Two new clinics were added to the list, at Princeton Hospital and Salem Memorial Hospital, and one clinic was deleted from the list because of inactivity and lack of organization. The American College of Surgeons inspected the clinics during the spring of 1953, and it is

our belief that 35 of the 39 clinics will receive their approval. Three of the four clinics will not receive approval only because they have been operating less than one year. The fourth clinic will possibly be eliminated from the list of clinics if improvement is not made.

DURING the year the clinics received approval for the expenditure of \$36,614.28 for new equipment, all of which is within the provisions of Part I of the American Cancer Society program. In addition to this amount \$50,311.00 was paid to the clinics under Part IV of the program for nursing and clerical overhead and diagnostic services. From September 1, 1952 to August 31, 1953, these clinics report that 23,437 visits were made by indigent or medically indigent cancer patients, of which 1,876 were new referrals and 21,561 were

revisits. 9,778 visits were made for x-ray therapy. Of the 1,876 new patients seen at the clinic, 869 were diagnosed as having malignancies.

The following is a list of clinics which received financial aid during the past year.

All Souls Hospital, Morristown
Atlantic City Hospital, Atlantic City
Barnert Memorial Hospital, Paterson
Beth Israel Hospital, Newark
Bridgeton Hospital, Bridgeton
Burdette Tomlin Memorial Hospital, Cape May
Court House
Burlington County Hospital, Mount Holly
Christ Hospital, Jersey City
Cooper Hospital, Camden
Dover General Hospital, Dover
East Orange General Hospital, East Orange
Elizabeth General Hospital, Elizabeth
Englewood Hospital, Englewood
Fitkin Memorial Hospital, Neptune
Hackensack Hospital, Hackensack
Holy Name Hospital, Teaneck
Irvington General Hospital, Irvington
McKinley Hospital, Trenton
Mercer Hospital, Trenton
Monmouth Memorial Hospital, Long Branch
Morristown Memorial Hospital, Morristown
Muhlenberg Hospital, Plainfield
Newcomb Hospital, Vineland
North Hudson Hospital, Weehawken
Overlook Hospital, Summit
Passaic General Hospital, Passaic
Paterson General Hospital, Paterson
Perth Amboy General Hospital, Perth Amboy
Presbyterian Hospital, Newark
Princeton Hospital, Princeton
Salem County Memorial Hospital, Salem
St. Barnabas Hospital, Newark
St. Francis Hospital, Trenton
St. Joseph's Hospital, Paterson
St. Mary's Hospital, Hoboken
St. Mary's Hospital, Passaic
St. Michael's Hospital, Newark
Underwood Hospital, Woodbury
West Jersey Hospital, Camden

In addition to the tumor clinics mentioned above the American Cancer Society gives financial aid to an isotope center which was established at the Beth Israel Hospital, Newark, in 1951. This center reports that 1,669 patients were treated last year, of which 304 were new referrals. Of these new patients treated, approximately 56 had possible malignancies. At Newcomb Hospital in Vineland, a second clinic has been organized and, at the end of the year, was in operation to a limited extent.

The activities of the center were expanded in April 1953 to include the use of radio-active colloidal gold 198. The administration of this

material to indigent or medically indigent cancer patients will be subsidized by the American Cancer Society. The agreement with the center includes the cost of hospitalization for these patients while undergoing treatment with colloidal gold 198.

SEEING the need for a change in the basic pattern for the proper use of radium, this committee approved a change in the units of radium as set up in Part I of our program. This change provided for radium distribution in 5 mg. cells and 1 mg. cells. This will allow for low and high intensity moderation treatments.

This change was offered to the American Cancer Society clinics having old radium in various sized capsules or needles. It stipulated that the American Cancer Society would pay for the exchange if desired by the clinic. To date many have taken advantage of the offer.

Other phases of the medical program through which assistance is given New Jersey cancer patients who are indigent or medically indigent are as follows:

Special Medications: High cost medications are supplied the cancer patient by the American Cancer Society. During the past year, \$26,650 was allocated by the American Cancer Society's 21 county chapters for this service.

Visiting Nurse Service: Visits were made by the 38 visiting nurse associations under contract with the New Jersey Division. The cost of this service was \$35,391.06 for the period September 1, 1952 to August 31, 1953. As compared with 1952 there was an increase of over 414 visits to indigent or medically indigent cancer patients at an additional cost of \$8,346.06. Visits are made to patients upon the recommendation of the family physician or of a cancer clinic, and after approval is given by the county chapter involved; payment is assumed by the American Cancer Society.

Radon Seeds: At the expense of the division, gold radon seeds are made available to New Jersey physicians for administration to cancer patients. For this purpose, \$8,000 was allocated last year.

As an aid to the program, over 2,000 New Jersey physicians have indicated their willingness to conduct health maintenance examinations in their offices. New Jersey physicians have also cooperated with the society by accepting the chairmanships of the service and education programs of the society and have supplied professional speakers for meetings of laymen.

Cardiovascular Diseases

JOHN H. ROWLAND, M.D., Chairman, New Brunswick

THE accomplishments of the committee during the year 1953-54 are as follows:

Definition of function:

1. To act as advisory committee to the Subcommittee on Public Health of The Medical Society of New Jersey.
2. On authorization of the Medical Society, to participate in the various projects established for the welfare of the cardiovascular patient.
3. To study various questions concerning the cardiovascular patient when requested by The Medical Society of New Jersey.
4. To assemble and classify facts, in order to make available information for any organization, group, or individual relative to any questions concerning the welfare of the cardiovascular patient.
5. To prepare for the Subcommittee on Public Relations information relative to the cardiovascular patient.
6. To inform county medical societies concerning projects relative to the cardiovascular patient when such projects are approved by the Medical Society.
7. To suggest support and complete co-operation between county medical societies and other interested groups.

Questionnaires were sent out to determine the activity of the county committees on cardiovascular diseases.

Replies were received from the following counties:

Burlington County	Monmouth County
Camden County	Passaic County
Cape May County	Salem County
Essex County	Union County
Hunterdon County	Warren County
Middlesex County	

From these questionnaires and other sources of information, it was revealed that:

1. Clinics are available for diagnosis and treatment of cardiovascular diseases in the following counties:

Atlantic County
Atlantic City Hospital, Atlantic City

Bergen County
Englewood Hospital, Englewood
Hackensack Hospital, Hackensack
Hasbrouck Heights Hospital, Hasbrouck Heights
Camden County
Heart Clinic of Cooper Hospital, Camden
Heart Clinic of West Jersey Hospital, Camden
Our Lady of Lourdes Hospital, Camden
Cumberland County
Bridgeton Hospital, Bridgeton
Newcomb Hospital, Vineland
Essex County
Babies' Hospital-Coit Memorial, Newark
Beth Israel Hospital, Newark†
Clara Maass Memorial Hospital, Newark
Presbyterian Hospital, Newark
Hospital of St. Barnabas, Newark
St. Michael's Hospital, Newark†*
St. James Hospital, Newark
Newark Health Department, Newark
East Orange General Hospital, East Orange
Orange Memorial Hospital, Orange
St. Mary's Hospital, Orange
Irvington General Hospital, Irvington
Mountainside Hospital, Montclair*
St. Vincent's Hospital, Montclair
Essex County Isolation Hospital, Belleville
Hudson County
Bayonne Hospital, Bayonne
St. Mary's Hospital, Hoboken
Medical Center, Jersey City
Mercer County
William McKinley Hospital, Trenton
Mercer Hospital, Trenton
St. Francis Hospital, Trenton
Middlesex County
Middlesex General Hospital, New Brunswick*
St. Peter's General Hospital, New Brunswick†
Perth Amboy General Hospital, Perth Amboy
Monmouth County
Monmouth Memorial Hospital, Long Branch*
Fitkin Memorial Hospital, Neptune*
Morris County
Dover Hospital, Dover
All Souls Hospital, Morristown
Morristown Memorial Hospital, Morristown
Passaic County
Beth Israel Hospital, Passaic
Passaic General Hospital, Passaic
St. Mary's Hospital, Passaic
St. Joseph's Hospital, Paterson
Paterson General Hospital, Paterson
Nathan & Miriam Barnert Memorial Hospital, Paterson
Union County
Elizabeth General Hospital, Elizabeth*
St. Elizabeth Hospital, Elizabeth
Muhlenberg Hospital, Plainfield*
Warren County
Warren Hospital, Phillipsburg

The hospitals marked with an asterisk have facilities for cardiac surgery plus:

Riverview Hospital, Red Bank and Salem Memorial Hospital, Salem.

Hospitals marked with daggers (†) have evaluation clinics.

In Passaic County evaluation clinics are being formed by the Passaic County Heart Association.

In Union County, evaluation clinics are being considered.

Research is being done in the following counties:

Camden County

Cooper Hospital (The Relation of Liver and Biliary Tract Disease to Coronary Disease)

Hunterdon County

Hunterdon County Medical Center is doing some research in the prophylactic treatment of rheumatic fever

Passaic County

Pilot Study on rheumatic fever in the schools

As a result of the questionnaire, it was determined that the activity of the county society committees on cardiovascular diseases is sluggish in some counties. In other counties they have cooperated and united with the county heart association in order to avoid duplication of effort. This unification has made it possible to obtain personnel and funds provided by the county heart associations so that the various projects may be accomplished.

The counties in which the greatest activity

has taken place are those cooperating with the county heart association.

This committee, acting as an advisory committee to the Subcommittee on Public Health, must look forward to the work being done at the county level.

This committee is cooperating with the committee of the New Jersey Heart Association, which will present a program on the cardiac in industry in May 1954, at Newark.

Recommendations.

A continued effort to establish sufficient and adequate evaluation units for the cardiac in industry.

A continued effort for the establishment of additional and sufficient facilities for cardiac surgery.

Education of health groups and public service organizations regarding the requirements of the cardiovascular patient.

Education of physicians in order that they may understand the program in motion for the establishment of heart clinics, evaluation units, facilities for cardiac surgery, and research on rheumatic fever, arteriosclerosis, and hypertension.

Propose to the Subcommittee on Public Relations a campaign to insure the success of our projects.

Propose to the Subcommittee on Legislation that it support legislation enabling the cardiovascular patient to sign a waiver of his evaluated permanent disability in order that he may be employed by industry.

Inspire county committees on cardiovascular disease to be more alert to the need for community service in relation to the welfare of the cardiovascular patient.

Arrange for a governor's conference on the cardiac in industry to be held sometime in the fall.

Chronically Ill

WILLIAM H. HAHN, M.D., Chairman, Newark

THE Advisory Committee on the Chronically Ill met at the Society offices on February 28.

The committee felt that the program submitted in September 1953 should be continued. This program proposed the continuation of committees for the care of the chronically ill in each county society, whose function would be to establish a program for the care of chronically ill patients.

In view of rapid developments in the programs for the care of the chronically ill generally it is important that the medical committees maintain activity and provide leadership. A partial survey of the committees appointed two years ago—more than half of our counties were contacted—indicates a need for more activity in these programs. In

some instances there was great activity, in others a need for help.

Some of the developments during the past year have been:

The Division for Chronic Illness Control of the State Health Department announced the appointment of a Director of Research. It established centers throughout the state for the study of diabetes, epilepsy, and alcoholism. Active clinics have been supported.

Regional institutes have been held in different parts of the state to stimulate the development of visiting home maker services. A practical training course of eight sessions, for community home makers, will be conducted through Rutgers University Extension. The course will be given as needed at the request of the local community home maker service for groups of at least six trainees.

A handbook for community home maker services has been issued.

*A*N IMPORTANT survey on chronic illness is being conducted in Hunterdon County under the direction of Dr. Ray Trussell, Director of the Hunterdon County Medical Center. This is a joint project of the Hunterdon Medical Center, the National Committee on Chronic Illness, and the State Department of Health. Its purpose is to find the percentage of population in the county having any chronic disease; to watch the progress of chronic disease in those who have them, and to observe the development of these diseases in those who are now well. The information obtained will be available to the State Department of Health.

The State Health Department transferred its program for alcoholism control, cancer control, and heart diseases to the Division for Chronic Illness Control.

A review entitled "Chronic Disease in New Jersey 1931 - 1953" was issued by the State Department of Institutions and Agencies. Attention was called to improvements in institu-

tional care for chronically ill patients. These included standards for hospitals, nursing homes, infirmaries, boarding houses and homes caring for chronically ill patients, and the licensing of these institutions when inspection shows the standards have been met. Almshouses, too, are being inspected for approval as medical institutions for the care of patients.

A FEDERAL program for assistance to the totally and permanently disabled has been inaugurated.

In Essex County, the Board of Freeholders made facilities available at the Essex County Hospital, Belleville, for the provision of medical and surgical care for recipients of old age assistance, disability assistance and blind assistance.

Proposals which may affect programs for chronically ill patients and which will require study are found in the Hill-Burton act. These proposals concern the care of convalescents and rehabilitation.

The question of hospitalization reinsurance has a direct bearing on chronic illness insurance, and any specific proposals should be studied.

Services to patients under the responsibility of several state agencies should be studied to see if these services could be coordinated more advantageously.

Our committee suggests that a speaker on chronic illness be on the scientific program of the annual meeting of The Medical Society of New Jersey in 1955, and that an exhibit on chronic illness be sponsored for that meeting.

It is reported to the committee that in some instances it has been difficult for institutions caring for chronically ill patients to secure medical personnel. Our committee suggests that doctors who have been retired from positions because of age would be especially well qualified for this work.

The Committee suggests increased activity in aiding the development of county committees for the care of the chronically ill.

Conservation of Vision and Hearing

REINOLD W. TER KUILE, M.D., Chairman, Ridgewood

DURING this year our committee has undertaken the following projects:

1. Completion of the Standards for Vision and Hearing Testing of school children.
2. A hearing rehabilitation program.
3. A study on school reading clinics.
4. Initial studies on revised standards of vision and hearing requirements for motor vehicle operators.
5. Certain legislative proposals.

The standards for testing vision and hearing of school children have been approved by the Trustees and submitted to the State Board of Education for their approval. It is this Committee's opinion that the Snellen charts to test distance and near vision, plus classroom observation by the teacher and the child's progress in school, are the simplest, and certainly most accurate, tests for vision of these children. This committee also opposes the divorcing of vision testing from the physical examination or the introduction of non-medical vision examiners. It feels that the procedures as outlined in our standards and done by the regular school medical personnel are very adequate for detecting vision defects. Diagnosis and treatment are to be carried out by the proper medical specialist or hospital clinic.

Under the guidance of Dr. Eugene Dalton, a very important and far-reaching school-children hearing rehabilitation program of statewide scope is evolving. There is great need for this type of program, and the Committee plans to make concrete proposals as soon as possible. This same group is also working on new hearing standards for operators of motor vehicles and improved methods for testing hearing in school children.

A STUDY of the problem of remedial reading clinics for schools was made by Dr. Van Winkle. It was this committee's opinion that, since this problem involved psychology and psychiatry, it would be better handled by those groups, with ophthalmologists acting as consultants. Any non-medical participants should be supervised by medical personnel.

This Committee is planning to make specific legislative proposals regarding visual and hearing requirements for operators of motor vehicles in this state. It was felt that these should be deferred until reliable data could be obtained from the accident prevention clinic now being run by the Motor Vehicle Department. We have offered our support and cooperation to the Motor Vehicle Department in interpreting their findings and in supporting pending legislative proposals. Recent information indicates that this legislation has been approved.

This Committee opposed the recent law permitting schools to hire optometrists as school visual examiners. Optometry pushed this law through without consulting this committee or The Medical Society of New Jersey. Since there is no provision for medical supervision over this visual examiner and since the eye examination is most certainly a part of the general physical examination and reveals many general medical conditions, we feel that this separation of the eye examination from the general physical examination is unwise and contrary to accepted medical practice. We have, therefore, proposed that this law be either repealed or amended to provide for medical supervision of the methods used and decisions made by the optometrist examiner. This is certainly an invasion by optometry into the practice of medicine.

THIS committee also opposes the sale of glasses in stores directly to the customer without previous proper eye examination. We likewise oppose the practice of some optical companies of supplying safety glasses without properly and personally centering the lenses and fitting the frames. We have proposed legislative action against these practices.

A research program regarding orthoptic therapy in cerebral palsied children was considered to be good in principle, but the plan is regarded not acceptable as presented because of complete lack of proper medical control—not only in methods used but in interpretation of orthoptic findings. It failed also to consider the differentiation between purely eye muscle defects and strabismus due to central nervous system pathology. Also there is, at present, insufficient medical experience with these cases to know the value and effects of orthoptic training in these patients.

Maternal Welfare

JOHN D. PREECE, M.D., Chairman, Trenton

THE work of this committee is always fascinating. The advent of intravenous pitocin is now giving us a new set of complications. Recent advances in treatment and descriptions of new syndromes are giving us new approaches to old problems. One thing remains dominant—women still die in childbirth, and only through closely governed obstetrical supervision can we hope to reduce our maternal mortality rate.

Disturbing statements occur in the yearly report, in these days of advanced thinking in chemotherapy and antibiotics therapy, such as six deaths due to abortions. Twenty deaths due to hemorrhage in these days of blood banks and advanced methods of combating blood incompatibilities seem incomprehensible; and perhaps most disturbing of all are the three

deaths following elective operations for the purpose of sterilization. These have led the committee to the decision that the time has arrived for the compilation of a new set of standards to govern obstetrical procedures in this rapidly changing world. This should be the objective of the committee for the coming year.

The study of neonatal mortality was started this year by the inauguration of a pilot study in one county for a period of three months. A second study is now being started in another county.

The general picture of obstetrics in New Jersey is continuing the steady progress it has made for the past 20 years.

Mental Hygiene

HARRISON F. ENGLISH, M.D., Chairman, Trenton

THE Advisory Committee on Mental Hygiene met three times during the administrative year.

During the year, much thought was given by this committee to the Epilepsy Project which was initiated by the New Jersey Society for Crippled Children and Adults, upon the recommendation of The Medical Society of New Jersey. This project has grown and has made tremendous strides during the past year. The project could now better be described as a co-ordinated effort to improve the status of the epileptic by several separate programs organized for the benefit of the epileptic and coordinated in such a manner that they function collectively as one project for epilepsy, without duplication of effort and with a minimum of friction. The programs for the epileptic of (1) the New Jersey Society for Crippled Children and Adults, of (2) the State Department of Institutions and Agencies and of (3) the Division of Chronic Diseases Control of the State Department of Health, are all guided by an advisory council in which a responsible person identified officially with each program holds membership, as does this advisory committee representing The Medical Society of New Jersey. In the near future, it is envisioned that a seizure clinic will be established in four

general hospitals of the state, each one located in one of the four health districts of the state, to which physicians may refer difficult epileptic cases for consultation and recommendations for treatment.

The Advisory Committee on Mental Hygiene has met with and made recommendations to the Chairman of the Mental Health Committee of the Woman's Auxiliary to The Medical Society of New Jersey.

It has been called to the attention of the Advisory Committee on Mental Hygiene that the efficiency of the Mental Hygiene Clinics of the State Hospitals and the desirable expansion of such clinical services have been hampered by the inability to procure qualified psychiatrists in the clinical field of community and child psychiatry.

It is realized that training in the field of community and child psychiatry is a specialized one requiring at least two more years of training than that required for the general psychiatrist, according to standards set by The American Association of Psychiatric Clinics for Children and the American Psychiatric Association Sections on Child Psychiatry.

The Committee is studying steps necessary to develop a sound preventive program.

Nutrition

S. WILLIAM KALB, M.D., Chairman, Newark

THE Nutrition Committee reports the following activities:

Participation in a Nutrition Institute sponsored by the Home Economics Association, and held in Newark.

Participation in a survey on eating habits, which was conducted by Dr. Babcock of Rutgers University in the Hunterdon County public schools. The questionnaire and scoring system summarized the results of this survey. It showed that most of the children had good eating habits and that their diet regularly contained plenty of meat, citrus fruits, tomatoes, green vegetables, and bread and butter. However, the consumption of milk was found to be somewhat lower than recommended, and many children apparently do not eat enough eggs, with the result that one-third of the children obtain less calcium and protein than is considered desirable for growing children.

In November the Nutrition Committee voted to recommend to the Society a "Weight Reduction Week" Investigation disclosed that to conduct this program on a statewide basis during 1954 was not possible, however, because the time available was too short and the expense involved too great. It is suggested that such a program be considered for the year 1955.

In response to numerous inquiries concerning the use of sweet drinks containing sucaryl, which beverages it is claimed are free of calories, investigation on the part of the committee disclosed that an average glass of such beverages contains approximately three calories. The committee also has set up standards of low calory foods, with the intent of releasing these standards to restaurants upon request. These standards are to be referred to the Subcommittee on Public Health for its consideration.

Rehabilitation and Physical Medicine

HENRY H. KESSLER, M.D., Chairman, Newark

IN OCTOBER 1953 the Advisory Committee on Rehabilitation and the Advisory Committee on Physical Medicine were consolidated to become the Advisory Committee on Rehabilitation and Physical Medicine. Seventeen physicians are currently members of the committee.

In line with the objectives expressed and approved in the annual report for 1953, the following activities were carried out by the Advisory Committee between March 1953 and March 1954:

In May 1953 the committee sponsored a literature table at the annual convention of Region II of the National Rehabilitation Association which was held in Atlantic City. Literature describing various aspects of rehabilitation in the state of New Jersey was displayed and distributed to persons attending the convention. Several members of the committee and a secretary were present at the literature table at various times during the convention.

On October 2, 1953, a Workshop on Employment of the Physically Handicapped was held at the Kessler Institute for Rehabilitation under sponsorship of the Advisory Committee on Rehabilitation. About two hundred doctors, nurses, therapists, social service workers and educators were present at the seminar.

Four talks were delivered in the morning. Mr. George Nelson of the International Association of Machinists spoke on the viewpoint of labor, Mr. John M. Convery of the National Association of Manufacturers presented the viewpoint of management, Mr. John V. Grimaldi presented the viewpoint of insurance, and Dr. Henry H. Kessler spoke on the viewpoint of medicine.

In the afternoon there was a panel on rehabilitation of the tuberculous, jointly led by Dr. Joseph A. Smith and Mr. John J. Jennings; a panel on rehabilitation of the cardiac, jointly led by Dr. Henry C. Crossfield and Mr. Howard W. Dayton; and a talk on re-

habilitation of the older worker by Dr. Martin Gumpert.

Two of the papers delivered at the seminar were published in the JOURNAL of The Medical Society of New Jersey. The authors are Dr. Martin Gumpert, who discussed rehabilitation of the older worker, and Mr. George Nelson, who presented the viewpoint of labor.

In addition, an article by Dr. Henry Brod-kin, a member of the committee, was published in the JOURNAL during 1953. Other members

of the committee are at work on articles to be considered for publication in the JOURNAL.

In November 1953 a request was received from Dr. C. Byron Blaisdell, Chairman of the Subcommittee on Legislation, for the opinions of the committee members on the subject of licensing physical therapists in the State of New Jersey. The chairman of the Advisory Committee circulated this request to the members and their responses were turned over to Dr. Blaisdell for his further consideration.

Rural-Community Health

G. FREDERICK MOENCH, M.D., Chairman, Robbinsville

A CHRONOLOGIC report of events and activities of the chairman and the committee follows:

June 1953—The chairman received A.M.A. publications which included A.M.A. President Edward J. McCormick's 9 point program for the improvement in medical care set-up for the nation, as presented in an address before the House of Delegates in New York City. These nine points have served the committee as informational background and as a guide in its deliberations, along with the policies and objectives of The Medical Society of New Jersey. A copy of the material was sent to each of the District State Health Officers (M.D.'s), Department of Health, for their information and guidance in working with the component medical societies in their respective districts on related public health problems and programs.

July, 1953—The chairman attended the meeting of committee chairmen and officers of the Society, called by Dr. Decker, for the orientation and guidance of the chairmen. The statement of objectives, procedures, policies, and the copy of the By-Laws pertaining to the committees have been most helpful in the implementation of this committee's responsibilities. A brief verbal report of the committee's program was rendered at the meeting. It is hoped that this type of orientation and education will be continued.

August, 1953—A list of the committee membership was sent to the A.M.A. for inclusion in its roster of State Rural-Community Health Committees.

A meeting of the Woman's Auxiliary Rural-Community Health Program Committee was attended by the chairman. Also present were the Community Health organizers from each of the four State Health Districts and the chief of the Board of Public Health Nursing. It was a mutual briefing session for approved program planning and implementation.

The Advisory Committee met this month. The members displayed keen interest, raised pertinent problems, and made recommendations which were approved for presentation to the Subcommittee on Public Health. Both the problems and their solutions involved many of the other committees of the Medical Society and require mutual cooperation, assistance and action in their planning for solution.

A request was received from the Regional Director of the A.M.A. Council on Rural Health for the annual report of the Council, due on September 1, 1953. It was reported at that time that the committee had approved the Auxiliary program but that there was insufficient time to summarize tables of activity by the dead-line. The summary was submitted subsequently.

September, 1953—The chairman attended the meeting of the Subcommittee on Public Health and reported on the activities of the advisory committee and the Auxiliary program.

October, 1953—At the request of the president, the chairman attended the metropolitan regional meeting of the New Jersey Council for Local Public Health Services. Dr. Decker

pointed out in his letter that "part of the continuing program of the advisory committee is the project to aid and assist in the organization of county-wide community health councils in cooperation with the State Council." These programs are operating, continuing and long-range in scope, and will be discussed at a future meeting of the committee.

November, 1953—The chairman attended the meeting of the Subcommittee on Public Health and reported on the activities of the advisory committee.

The committee was notified by the Board of Trustees that the following program was approved:

1. Multiphasic screening methods in case finding and technics for administering same.

2. More comprehensive and extended coverage of local communities by public health nurses through boards of health and visiting nurses associations, et cetera.

3. Continued aid and assistance in the organization of county-wide community health councils.

4. Continued aid and support of the movement for adequate local public health departments.

Since no new requests for advice or counsel have come to the attention of the committee, no further meetings have been called. It is anticipated that a meeting will be held during the State Society annual meeting in May. No additional recommendations in line of program are being made in this report.

School Health

JOSEPH R. JEHL, M.D., Chairman, Clifton

ALTHOUGH no specific problems were referred to the committee by the Subcommittee on Public Health, two meetings were called to discuss pertinent matters and to explore the subjects which were of interest to the members of the committee.

At the first meeting no action was taken.

The second meeting discussed at length the question of "Polio Immunization" and the group approved of the plan, provided proper safeguards are taken to insure complete comprehension on the part of all concerned.

Venereal Disease Control

GEORGE W. IRMISCH, M.D., Chairman, Trenton

A SUGGESTION of the committee was approved at the last annual meeting that the card, used by physicians to report venereal disease, be revised to include a space where the physician would request assistance in venereal disease contact study. This year ten revised cards were sent to each physician to improve venereal disease contact study.

Members of the committee attended the Conference on Venereal Diseases in Atlantic

City. Dr. Adele Shepard, the consultant for this committee, was actively engaged in the program. The summations of the meeting are being incorporated with local statistics to formulate a report for the JOURNAL of The Medical Society of New Jersey.

The committee voted in favor of an annual luncheon meeting which this year will be held Tuesday, May 18, 1954, in Atlantic City at the time of the state convention.

Medical Practice Advisory Committees • • •

(Reference Committee "E")

Anesthesiology

EDWARD T. LAWLESS, M.D., Chairman, Upper Montclair

TWO meetings of this committee have been held during the year. There are no recommendations to be made to the Medical Society at

this time, nor were any opinions sought from the committee by the Society regarding anesthesiology during the current year.

General Practice

HARRY TAFF, M.D., Chairman, Newark

THE Advisory Committee on General Practice received no official assignments for study this year from either the Board of Trustees or the Subcommittee on Medical Practice, nor did it have occasion to call to the attention of the Society new matters for official consideration. In consequence, the meetings of the advisory committee were given over largely to reappraisal and reaffirmation of recommendations previously made to insure fuller and more adequate recognition of the general practitioner in the contemporary practice of medicine.

Among the principal points to be re-emphasized are the following:

1. The establishment of adequate general practice sections in all general hospitals of the state, to include taking care of the clinics, and voting representation in the administra-

tion of the hospitals. The committee feels strongly that the fact that a physician is a general practitioner should not prevent his becoming a member of the associate attending staff or, in special cases, even head of a service, if he is properly qualified.

2. That provision be made by the Medical-Surgical Plan for the payment of appropriate fees for physicians assisting at either surgical or obstetrical procedures in hospitals. The Plan should likewise allow the same payment for emergency medical or other emergency office procedures as it allows for office emergency surgical procedures.

3. The general practitioner should have more adequate representation at all levels in organized medicine, wherever feasible.

In short, that the general practitioner be recognized for his worth in all the various phases of the practice of medicine.

Group Practice

CEDRIC C. CARPENTER, M.D., Chairman, Summit

THERE were no meetings of this committee during the year.

The Medical Society had no uncompleted projects in its files, and no matters were brought to our attention.

The committee reaffirms its previous po-

sition that group clinics could do much to relieve overcrowding in hospitals if their medical and surgical treatments were endorsed by the Medical-Surgical Plan and other insurance plans.

Nursing

ANDREW C. RUOFF, M.D., Chairman, Union City

IN this past year the project in connection with the Revision of Standing Orders for Public Health Nurses has been referred to this committee.

In this connection, it is important to note that many other committees outside of the State Medical Society representing the State Board of Health and the State Board of Nursing have had this same problem under consideration. Dr. Frederick Moench, Deputy Com-

missioner of the State Department of Health, has prepared a very fine list of suggested general principles or procedures relative to orders for public health nurses.

Standing orders for public health nurses are frequently approved on the county level, but this committee will endeavor to have these orders as uniform as possible so that they will serve as a guide to the county societies.

Radiology

JOHN L. OLPP, M.D., Chairman, Englewood

THE Advisory Committee on Radiology had no problems referred to it for consideration during the year; hence, there is no report of

committee activity. The membership is at the service of the state society at such time as our assistance is needed.

Welfare Services

A. M. K. MALDEIS, M.D., Chairman, Camden

DURING the current year the Advisory Committee on Welfare Services met with representatives of the Department of Institutions and Agencies of New Jersey.

Matters relative to the adequacy of medical care for persons receiving such care at public cost, the means of distribution and the compensation for such care plus other pertinent questions were discussed.

The representatives of the Department of Institutions and Agencies did not favor the establishment of a single fund for payment of welfare services, particularly at the present time. They likewise considered it impractical to create uniform fees for similar services among various agencies of the State.

It was brought out that medical service to the state welfare agencies is adequate and that no lack of medical care is known.

The representative of the Commission for the Blind stated that he would appreciate any effort by The Medical Society of New Jersey toward making blind persons (as a group) eligible for benefits of the Hospital and Medical-Surgical Plans. This the committee recommends to the Society for investigation and proper action.

(The Subcommittee on Medical Practice, in reviewing this report, recommended that the above recommendation be referred to Medical-Surgical Plan and Hospital Service Plan.)

Workmen's Compensation and Industrial Health

ARTHUR F. MANGELSDORFF, M.D., Chairman, Bound Brook

THIS Advisory Committee has had a number of meetings during the past year. Its activities have included:

- 1.) Discussion of means for correcting the practice of certain physicians who testify in compensation court cases.
- 2.) Investigation of the practice of certain insurance carriers in arbitrarily reducing physicians' fees in compensation cases.

A meeting was held with representatives of the insurance carriers and the following recommendations submitted:

- 1.) Each county medical society establish and maintain a committee of arbitra-

tion for disputed compensation case fees similar to the one that is now functioning in Essex County.

- 2.) All disputes regarding compensation fees are to be referred to this committee.
- 3.) A joint committee should be formed composed of members of this committee and members of the Medical Committee of the Newark Casualty Insurance Claims Managers' Council.
- 4.) Those disputed cases which cannot be handled satisfactorily by the county society committee should be referred to this joint committee for further consideration and recommendation.

(Reference Committee "C")

State Board of Medical Examiners of New Jersey

E. S. HALLINGER, M.D., Secretary, Trenton

DURING the period of January to December, 1953, the Board examined sixty-three applicants for a license to practice medicine and surgery. Eleven of the applicants were graduates of osteopathic colleges.

The Board also examined eighteen applicants for a license to practice chiropody.

TABLE 1

Number of Candidates for the 1953 Examinations, Classified as Graduates of Medical Colleges in the United States and Foreign Countries

	Total	Passed	Failed
Medical			
United States			
Graduates of			
Medical Schools	33	31	2
Graduates of			
Osteopathic Schools	11	11	
Canada	1	1	
Switzerland	3		3
Italy	11	5	6
Hungary	2		2
Yugoslavia	1	1	
Chiropody			
United States	18	16	2
Total	80	65	15

All candidates were citizens of the United States.

Three hundred and nineteen licenses were issued to applicants by endorsement of a license from another state or a diploma from the National Board of Medical Examiners who presented credentials to prove they could meet the requirements for examination that were in force in New Jersey at the time they were examined.

ALL credentials covering medical and hospital work submitted to the Board were verified by questionnaires sent to the colleges and hospitals in this country and abroad before a license was issued.

The laws governing the practice of medi-

cine and surgery, and osteopathy do not provide for an annual registration. The Board does not, therefore, know whether the number of licentiates in the state now in practice is increasing or decreasing.

TABLE 2.

Licentiates by Endorsement Classified as Graduates of Colleges in the United States and Foreign Countries

Countries	Total
United States	291
Great Britain	1
Austria	5
Switzerland	3
Italy	6
Czechoslovakia	1
Germany	3
France	1
Canada	3
Hungary	1
Poland	1
Lebanon	2
Lithuania	1
	319

TABLE 3.

Number of Physicians and Surgeons and Osteopaths Endorsed to Other States, the Number of Licentiates of Whose Death the Board Received a Report and the Number of Licenses Revoked

Physicians—endorsed to other states	74
Osteopaths—endorsed to other states	4
Physicians—deceased	61
Osteopaths—deceased	2
Osteopathic—licenses suspended	1
Chiropody—licenses revoked	1
Midwifery—licenses revoked	1
Midwifery—petition for restoration of license pending	1

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Annual registration would give the Board accurate information relative to the number of physicians practicing in New Jersey and would enable the licensed physicians to assist the

Board in enforcing the law by reporting unlicensed physicians in their vicinity.

THE laws governing the practice of chiroprody, chiropractic and midwifery provide for an annual registration. Our records show a decrease of nine in the number of chiropodists registered on November 1, 1953, and a decrease of nine midwives for the same period. Chapter 233, P. L. 1953, the new chiropractic law enacted on July 14, 1953, provides for an annual registration of chiropractors. One hundred eighty-three chiropractors registered for the year 1953-1954.

ENFORCEMENT

FOLLOWING is a brief report of the Board's activities in enforcing the laws which they administer:

Court Cases—Violations of Medical, Etc., Laws	
Convicted, pleaded guilty or settled	29
Pending in the courts	14
Cases lost	1
Cases dismissed	1
	<hr/>
	45

Hearings Before Board	
Osteopathic—licenses suspended	1
Chiropody—licenses revoked	1
Midwifery—licenses revoked	1
Midwifery—petition for restoration of license pending	1
	<hr/>
	4

Classification of Investigations and Inspections	
Type of Cases Investigated	
Druggists practicing medicine	20
Prescribing herbs and drugs	7
Unlicensed medical doctors	3
Practicing chiropody without a license	4
Licensed chiropractors exceeding license ..	3
Unlicensed chiropractors	78
Unlicensed osteopaths	1
Naturopaths	24
Physiotherapists	1
Osteopathic suspension	1
Chiropody revocation	1
Midwifery revocations	2
	<hr/>
	145

Analysis of Inspections and Investigations	
Total number of investigations and inspections made	145
Total number of visits made and treatments received in making the investigations and inspections	380
Average number of visits per investigation	2.7

Medical Service Administration of New Jersey

BOARD OF GOVERNORS

THE activities of Medical Service Administration during 1953 have been limited to the operation of the City of Newark Medical Plan. This Plan, designed to meet the needs of the indigent and medically indigent of the City of Newark, is a reimbursement plan rather than an insurance plan. It provides payment on a fee-for-service basis for services rendered by physicians of the patient's choice for care of eligible persons confined to their homes by illness. The Plan continues to demonstrate successfully the cooperation of an official health agency with a voluntary agency controlled by the medical profession in helping to solve the problem of medical care of the indigent and medically indigent. It continues to arouse nation-wide interest as a pioneer effort to

solve this problem within the framework and approved principles of organized medicine. The Council on Medical Service* of the American Medical Association recently completed a detailed study of 15 of the most successful community or state-wide plans now in operation for the care of the medically indigent. Newark was one of the cities studied. Ten individual reports on the study have appeared in The Journal of the American Medical Association. Because interest in this subject has increased and requests for reprints of these reports continue, the ten reports have been published together in a pamphlet entitled "A Report on Medical Care for the Indigent in Ten Selected Communities." (Copies may be obtained by writing to the Council on Medical Service, A. M. A., Chicago, or telephoning the office of Medical Service Administration)

THE following is an excerpt from the report on the City of Newark: "The Medical Service Administration, organized for state-wide service, is used only in Newark and only for general assistance payments, although it appears to be an efficient agency to handle payments to physicians for all programs." Concerned with the problem of how to assist medical societies in evaluating indigent medical care plans, the Committee on Indigent Care of the American Medical Association has developed a set of "guides" which were approved by the House of Delegates in December 1953. These practical guides, which were developed from the working data obtained during the survey, are contained in the preface of the pamphlet.

The following table depicts the experience of the Plan over a seven year period, from 1947 to 1953 inclusive, (statistics from 1944, 1945 and 1946 are listed in previous reports) showing actual costs and reflecting the changing economic picture.

In interpreting this table, may we remind you that the indigent are those whose names appear on the welfare rolls of the City of Newark and that the medically indigent are those who, in the opinion of the Social Service Bureau of the City Board of Health, while

having a sufficient income to meet the routine cost of a satisfactory standard of living, do not have sufficient income to pay for adequate medical care. Since the only fixed, or well-defined group are the indigent, the cost per capita in this report is limited to the indigent group. It is impossible to estimate the size of the medically indigent population.

AS PRESENTED, the figures pertaining to the medically indigent load consist only of those persons classified as medically indigent when requesting medical services, hence their costs are depicted on a cost per case basis only, rather than on a per capita basis.

The Plan has operated very smoothly in this past year. The relief load and the claims for relief cases have decreased approximately 8% below 1952. The cost per capita of relief load has decreased from \$1.77 per year in 1952 to \$1.48 per year in 1953. The decline in the relief load is attributed in large measure to the continued high level of employment in northern New Jersey during the first half of 1953 and to legislation making it possible for totally disabled persons to be accepted by the Essex County Welfare Board.

INDIGENT (RELIEF) PERSONS

Year	1947	1948	1949	1950	1951	1952	1953
Mean number of persons on Welfare Rolls during year	2995	4274	7986	7804	4977	3794	3500
Number of cases during year	—	—	—	—	—	—	1481
Value of approved services	\$7,823.00	\$8,589.50	\$12,046.00	\$13,092.00	\$9,105.00	\$6,726.50	\$5,003.00
Cost per capita of relief load							
per year	2.61	2.00	1.51	1.50	1.83	1.77	1.48
per month	0.217	0.167	0.126	0.125	0.152	0.147	0.123
Cost per case							
per year	—	—	—	—	—	—	3.378
per month	—	—	—	—	—	—	0.281

MEDICALLY INDIGENT CASES*

Number of cases during year	2734	3283	4155	4446	3450	3409	2648
Value of approved services	\$10,633.50	\$12,775.50	\$15,119.50	\$15,298.50	\$13,705.50	\$11,366.00	\$8,579.50
Cost per case							
per year	3.89	3.89	3.639	3.441	3.972	3.334	3.24
per month	0.324	0.324	0.303	0.287	0.331	0.278	0.27

* The word "case" means family as distinguished from "person" referred to under report on indigent.

MEDICAL care of the indigent and medically indigent under a plan like the City of Newark Plan, meets with the hearty approval of patients, physicians and governmental agencies. The standard of medical care is higher and the costs to the municipality are less than under other systems. The greatest financial saving is due to the fact that under such a plan, many people are cared for at home and a fewer number of people are hospitalized.

The Medical Service Administration has demonstrated its value as an agency serving to provide medical care to indigent and medically indigent persons on a reimbursement rather than an insurance basis. The procedure is applicable to any community in New Jersey.

The future growth and usefulness of Medical Service Administration, which was organ-

ized by the medical profession, depend entirely upon the willingness of the individual physician to accept this great opportunity for practical service. The understanding and participation of all our physicians are needed.

That segment of the population which includes the indigent and medically indigent increases or decreases with changing economic conditions. The value of the Medical Service Administration to The Medical Society of New Jersey and to the people of our state would be enhanced and more readily discernible should a business recession of any serious proportions occur in the near future.

The Board of Governors wish to express to The Medical Society of New Jersey their deep and sincere appreciation of the moral and financial support so generously given to Medical Service Administration over the thirteen years of its existence.

Medical-Surgical Plan of New Jersey

THE BOARD OF TRUSTEES

MEDICAL-SURGICAL Plan of New Jersey has continued its impressive rate of growth during the twelve months ending April 1, 1954. A summary of statistics showing the progress of the Plan by calendar years is appended to this report.

In 1953, for the first time, the total operating expense ratio of the Plan was less than 10 per cent of earned subscription income for the year. The expense ratio for the year stood at 9.6 per cent, as compared to 10.8 per cent in 1952, 10.9 per cent in 1951 and 12.9 per cent in 1950. The average operating expense ratio among the larger Blue Shield Plans, during the first nine months of 1953, was 11.35 per cent of subscription income.

The Plan paid 85.2 cents of every subscription dollar received in 1953 to physicians in claim payments. This compares to an average claim payment ratio of 80.4 per cent among the larger Blue Shield Plans.

The Plan's proportion of net earned income added to reserve for 1953 was 5.2 per cent which represents a somewhat less favorable experience than in 1952, when 9.0 per cent of subscription income was transferred to re-

serve. The larger Blue Shield Plans earned an average of 8.24 per cent in the first nine months of 1953.

In terms of gross sums earned and disbursed during 1953, the Plan's subscription income was 36.2 per cent greater than in 1952; the dollar value of claims incurred was 45.8 per cent greater in 1953 than in 1952, while the Plan's reserve was increased by 31.7 per cent over the reserve at the end of 1952. The Plan's earned reserve for 1952 was increased by 39.5 per cent over the earned reserve for the year 1951.

THERE has been a substantial net growth in enrollment during 1953 even though certain deflationary economic tendencies were reflected in an increased ratio of cancellations to new enrollments during the latter part of the year.

The total Plan enrollment as of March 1, 1954 was estimated at slightly less than 1,200,000 persons. This enrollment represents approximately one-fourth of the population of New Jersey.

The growth of Plan service in recent years is evidenced by the following summary.

Calendar Year	Total Cases Paid by Plan	Attended by Participating Physicians	
		Number	Percentage
1953	132,722	103,743	78.2
1952	91,690	71,061	77.5
1951	65,438	52,056	79.6
1950	48,255	39,418	81.7

PARTICIPATION BY PHYSICIANS

THUS, it is seen that 78.2 per cent of all Plan cases were attended by Participating Physicians in 1953*, whereas 77.5 per cent of all Plan cases were attended by Participating Physicians in 1952. As of December 31, 1953, Plan records showed that 80.5 per cent of all physicians of record in New Jersey were Participating Physicians, as compared to a participation ratio of 78.1 per cent at the end of 1952.

REPORT ON PROPOSED NEW CONTRACT

THE House of Delegates of The Medical Society of New Jersey, at its annual meeting in May 1953, approved (with certain minor amendments and reservations) a Supplemental Report presented by the Plan containing the outline of certain specific changes which the Plan then proposed to incorporate in a revised Subscription Contract.

The principal reasons impelling the Plan to undertake a general revision of the Contract were set forth in the Supplemental Report as follows:

1. The overall need to progress — to provide a more attractive opportunity for voluntary pre-payment of medical services by the people of New Jersey—both on a group and a non-group basis. (The present 1949 Series Contract has been in effect almost five years.)
2. The need to reconsider the Plan's scope of coverage of both medical and surgical services.
3. The need to revise certain Contract provisions relating to the application of the income limit for service benefits that have proved unsatisfactory during the past several years.

* 13.6 per cent of Plan cases were attended by non-participating physicians in New Jersey in 1953. 8.2 per cent of Plan cases were attended by out-of-state physicians.

The principal Contract changes proposed by the Plan and approved by the House of Delegates were:

1. To maintain the existing income limit for service benefits at \$5,000, but to provide that such limit shall apply to the combined income of Subscriber and spouse (if any) — rather than to the income of the Subscriber only.
2. To eliminate prenatal care as an eligible service.
3. To provide for payment, on a medical care basis, for treatment of complications of pregnancy when treated in hospital.
4. To provide that surgical procedures presently eligible to a bed patient in hospital shall be eligible when rendered in the out-patient department of the hospital.
5. To provide payment, in accordance with the Schedule of Payments (but in an amount not to exceed \$50 in any case) for any operative procedure of an emergency nature when rendered outside of hospital.
6. To provide for payment, on the basis of medical care, within the limits of the contract, for post-operative care of a hospitalized surgical case, if such post-operative care is required beyond 14 days after the operation.
7. To increase the number of eligible days of medical care for a hospital patient from 21 to 30 days in a contract year.
8. To make the newborn infant an "eligible person" on date of birth, rather than on the seventh day of life as at present. (Medical care of the normal newborn would not be eligible for separate Plan payment.)
9. To eliminate consultations as an eligible service.
10. To provide that Plan payment for eligible services rendered by a non-participating physician shall be made to the Subscriber.

The House of Delegates approved certain qualifying recommendations concerning the compensation of the attending obstetrician in a maternity case in which actual operative or instrumental delivery must be effected by another physician. Also a study was requested of possible payment for emergency x-ray in treatment of accidental injuries outside of hospitals. The House urged restoration of consultations as an eligible service, provided that The

Medical Society of New Jersey be able to "establish qualifying criteria for the recognition of specialist consultants."

THESE recommendations have all been given consideration by the Plan in its continuing study of these matters.

On October 20, 1953, the Executive Committee of the Plan tentatively approved in principle a draft of the new Subscription Contract. This was submitted to and tentatively approved in principle by the Board of Trustees of The Medical Society of New Jersey at its meeting of October 25, 1953; the draft was tentatively approved in principle by the Board of Trustees of the Plan on October 27, 1953.

Immediately thereafter, on November 2, 1953, the tentative draft of proposed new Subscription Contract was presented to the Department of Banking and Insurance of New Jersey for review.

Since November 2, 1953, the Plan has had correspondence and meetings with the Department of Banking and Insurance regarding various specific provisions of the proposed Contract. As of March 18, 1954, however, the preliminary consideration of Contract terms has not yet been completed.

Subscription rates, therefore, have not been calculated as yet, pending completion of the preliminary study of Contract terms by the Department and completion of review of the Schedule of Benefits by the Plan.

The Board of Trustees, needless to say, cannot act finally upon a revised contract form until contract rates have been determined on the basis of an approved draft of contract terms and an approved Schedule of Payments.

Thereafter, it will be necessary that the entire contract, with rates, be submitted to the Department of Banking and Insurance for final approval.

SPECIAL FACTORS

THE Board of Trustees of the Plan regrets that it has not yet been able to complete the process outlined above and announce a definite date for the issuance of a revised Subscription Contract. Apart from the necessity of carrying out the steps already described, several other factors have arisen to prevent the Plan from making the early and rapid progress in the issuance of a revised contract which it had hoped

to make following the last meeting of the House of Delegates.

The drafting of the actual text of the proposed new contract brought to light certain new questions of administrative policy, some of which required extensive study. Questions of medical policy have arisen also, a few of which have been reviewed with the Board of Trustees of The Medical Society of New Jersey or with representatives of specialty groups concerned.

Conferences have been held during the year with representatives of industry and of labor unions whose memberships comprise a large proportion of subscribers of the Plan. Both the industrial and labor representatives have made proposals as to certain specific contract changes, and have requested the Plan to make further studies concerning some of these suggestions before taking a final decision as to the terms and provisions of the new Subscription Contract.

STILL another factor that has caused the Plan to delay or defer final decisions on the new Subscription Contract has been an accelerated increase in the incidence rate of claims against the Plan under the terms of the present Contract. Efforts have been made to determine the cause or causes of this tendency and thus to assess the likelihood of a further increase, in order to estimate the marginal safety factors that must be provided in the subscription rates for any new contract.

The Plan has also been requested to give consideration to possible expansion of benefits in such a way as to make eligible the services of certain professional groups whose services are presently not eligible for Plan payment. While all such proposals are given the most careful and sympathetic consideration, the Plan must at all times guard against any expansion of benefits which will result in a radical increase in Subscription Rates, or which depart radically from the basic purpose of the Plan—to provide essential medical, surgical and obstetrical service on a pre-payment basis, with service benefits for the lower income groups.

ACKNOWLEDGMENTS

THE Trustees of Medical-Surgical Plan take this opportunity to express appreciation to Hospital Service Plan of New Jersey for the many services rendered under our Joint Operations Agreement.

The Trustees also wish to express their deep appreciation of the continued support and cooperation of the Participating Physicians, and of the officers and members of The Medical

Society of New Jersey. The gratitude of all of us is likewise extended to the staff of the Plan for their loyal, devoted and efficient service.

SUMMARY OF OPERATIONS

Year Ended December 31	Earned Subscription Income	Claims Incurred Amount	% of Income	Operating Cost % of Income	Persons Enrolled End of Period
1942	\$ 11,148	\$ 5,395	48.4	51.1	4,131
1943	74,498	49,562	66.5	23.9	16,015
1944	187,708	135,605	72.2	18.9	30,427
1945	326,530	208,288	63.7	17.5	49,441
1946	540,227	370,576	68.6	16.8	88,088
1947	947,945	681,922	72.0	17.1	143,700
1948	1,524,814	1,203,651	79.0	15.0	236,604
1949	2,545,518	1,979,542	77.8	13.8	353,827
1950	5,252,060	4,278,098	81.5	12.9	499,882
1951	8,031,305	6,527,374	81.3	10.9	669,906
1952	10,952,158	8,720,257	79.6	10.8	997,303
1953	\$14,916,204	\$12,715,442	85.2	9.6	1,183,336

County Societies • • •

Atlantic

E. HARRISON NICKMAN, M.D., President, Atlantic City

IN THE spring of 1953 when I entered upon the duties of President of the Atlantic County Medical Society I outlined a number of objectives for the ensuing year. These included: first, coordination of the County committees with those of the State Society to facilitate the transaction of business; second, the development of good public relations among the members of the County Society as well as between the County Society and the public; third, the complete revision of our constitution so that it would not only be modernized but would integrate with the constitution of the State Society; fourth, the standardization of the contagious disease codes of the several municipalities within the County. These objectives are now accomplished facts and stand as a testimonial to the splendid effort of the

committees involved as well as to the undivided cooperation of the members of the Society. Two men, each working in his own way, have been responsible for our intensive public relations program. Dr. Samuel Diskan, general chairman of the County public relations and publicity committees, a member of the State public relations committee and editor of the County Society's "Bulletin," has, with the assistance of a hard working staff, kept the doctor in a favorable light throughout the year with his press releases, radio programs, and his very "newsy" and intimate "Bulletin." Dr. Matthew Molitch, vice-president of the County Society and chairman of the program committee has given us a most unusual series of programs this year. He has succeeded in bringing us speakers not only of medical interest but also

of interest to lay groups. We have played host to the Bar Association, the clergy, and the health and welfare agencies and institutions of Atlantic County. My congratulations and personal thanks to these two men and their staffs for jobs well done.

During the past year a number of important projects were undertaken and completed. Foremost among them were the modernization of the constitution and by-laws under the able chairmanship of Dr. David B. Allman assisted by Drs. Hersohn, Ellenbogen and Stamps, and the work of Dr. Walter B. Stewart and his committee of Drs. McCracken, Davis, Grier, Goldstein, Infield, Rubba and

Dyer in developing a plan for uniform quarantine laws in the municipalities of Atlantic County. The men of these committees are to be commended for the successful completion of outstanding and difficult pieces of work.

In retrospect, the past year has been an extremely active one. Successful innovations have been made in our programs, our public relations have been improved and several important projects have been completed. I cannot help but feel that much of this could not have been accomplished without the teamwork that came from dynamic support of the individual members. I am grateful both for the Society and for myself.

Burlington

FREEMAN W. METZER, M.D., President, Riverside

Our society this year, thanks to the efforts of our Program Committee, under chairmanship of Dr. J. R. Wolgamot, has had an excellent series of scientific programs.

We have again tried to improve our public relations. This year we were asked to supply physicians for the Red Cross Blood Donor program in each locality. This we were able to do to the mutual satisfaction of both the Red Cross and county members who kindly donated their time.

The emergency medical service which the state society has been sponsoring this year has been in effect in Burlington County for about five years. We feel that it has been operating very satisfactorily and hope it will continue to do so.

Our monthly meeting in January was a combined one with the Burlington County Bar Association. Meetings such as this bring about

a better understanding between professional groups and we hope to meet with similar groups in the years to follow.

We have continued our support of the Burlington County Nursing Scholarship program started a few years ago. The county society offers each year a three year scholarship to the girl who is considered by our committee to be most deserving. By sponsoring such a program we feel that we are in a small way helping to provide nurses who are badly needed everywhere.

Our society came in for some nationwide publicity this year. One of our members, Dr. John E. Whitaker, was chosen as the typical "family doctor" on a nation-wide television program sponsored by S.K.F.

We regret to announce the death this year of Dr. Richard (Dick) Anderson. He was well known and held in high esteem by all of us and his loss is greatly felt.

Hudson

JOSEPH P. DONNELLY, M.D., President, Jersey City

WE ARE proud to report that Hudson County Medical Society, rounding out the third year of its second century of existence, has continued to grow and show steady progress as a community agency during the past administrative year.

Attendance at regular monthly meetings has been gratifying, both from a numerical standpoint and the standpoint of interest demonstrated by the general membership in scientific matters and all aspects of the Society's welfare and procedure.

Committees, both standing and special, have functioned with customary zeal and effectiveness. The executive committee has met in regular and special session throughout the year.

The most outstanding achievement of the past year is the establishment of an emergency and night-calls program in Hudson County. This project, long under consideration, was finally approved by the society and went into effect on January 1, 1954. The public press gave it due publicity. While it is true that minor defects in the over-all program have become apparent, as expected, the doctors participating in the emergency program have given it their full support, and it is our opinion that our society has made a noteworthy contribution to the community. The society voted to continue this program for a one year period.

During the year now closing, about seven-

teen young physicians have joined our ranks as active members. To the list of honorary members, we have added the name of Dr. Howard R. Dukes, Kearny.

SINCE last year, we record with deep regret, the loss by death of eight active members: Dr. Abraham J. Newman of Jersey City, April 19, 1953; Dr. William P. Braunstein of Weehawken, June 23, 1953; Dr. Charles H. Purdy of Jersey City, July 1, 1953; Dr. Grace Clark Morley of Hoboken, July 13, 1953; Dr. Walter I. Chapman, Jr., of Bayonne, September 27, 1953; Dr. Joseph F. Londigan, past president of this Society and of The Medical Society of New Jersey, of Hoboken, October 17, 1953; Dr. Abraham Urevitz of Union City, January 13, 1954; and Dr. Charles A. Peterson of Hoboken, February 18, 1954.

We joined with the Woman's Auxiliary on November 11, 1953, for one of the most delightful and gala parties in the history of the society. Throughout the evening we enjoyed dinner and dancing at the glamorous Casino-in-the-Park. Our Auxiliary has given us many years of the very finest support and we tried to express our thanks to them on that occasion.

On February 10, at the Hotel Plaza, we got together by ourselves for our traditional annual dinner.

Mercer

ERNEST F. PURCELL, SR., M.D., President, Trenton

RADIO PROGRAMS

DR. ARTHUR SACKS-WILNER, Chairman, with the assistance of the Public Relations Committee, the Woman's Auxiliary, and representatives of press and radio, has contributed outstanding service through the presentation of the second series of the radio program "Help Yourself to Health," which was launched February 1, 1954.

This is a community service program, presented to the public through the facilities of Trenton station "WBUD" with the cooperation of Mrs. Nan Rednor, known to radio listeners as "Nan About Town," and consists of panel discussions dealing with various phases of public health. The program continued through April 26, and was on the air every Monday evening at 7 o'clock.

The committee is also arranging a series of summer and fall public relations programs.

PRESS AND RADIO RELATIONS

ON DECEMBER 3, 1953, the Public Relations Committee held a dinner-meeting at the Trenton Country Club, with the Society acting as host to representatives of press and radio. Mutual problems were discussed at great length, with our group stressing throughout the entire discussion an earnest desire to cooperate with press and radio in the proper dissemination of medical matters, and that above all else, the welfare of the patient is paramount. It is hoped that through our efforts the layman will have a better concept of general health problems and what the profession is doing to solve them.

MEDICO-DENTAL LIAISON COMMITTEE

A MEDICO-DENTAL liaison committee was appointed. The committee has received a series of pertinent questions dealing with medico-dental problems. These questions and the answers thereto will be published in the May issue of The Journal of the Mercer Dental Society.

MEETING WITH BAR ASSOCIATION

ON APRIL 27, the officers of the society were the guests of the Mercer County Bar Association at their regular monthly meeting, at which time Dr. William E. Mountford and Dr. Henry S. Urbaniak presented the medical side of medico-legal problems, and two lawyers presented the legal side.

Following the dinner, your president discussed the early recognition of cancer, laying particular stress on the role that can be played by the lawyer in lending comfort to those about to undergo major surgery, and emphasizing the facilities available in Mercer County for surgical treatment by showing motion pictures of operations performed in Trenton.

CANCER DETECTION

ON APRIL 8, the Woman's Auxiliary, under the chairmanship of Mrs. John F. Johnson, with the cooperation of the American Cancer Society, the New Jersey State Department of Health, and members of the Public Relations Committee of the Mercer County Component Medical Society, presented an all-day public

program at Lit's Trenton department store, where a film on cancer detection was shown at two-hour intervals. Following the film presentation, a question and answer period was arranged through the cooperation of Mrs. John F. Johnson, of the Woman's Auxiliary, and Dr. George A. Corio, a member of the Public Relations Committee of the Mercer County Medical Society, during which members of the medical society answered questions asked by those in the audience.

BUFFET LUNCHEONS

THE serving of a buffet luncheon by members of the Woman's Auxiliary at the conclusion of each meeting of the medical society has been an outstanding success. The sociability engendered through this medium is very gratifying, and many favorable comments have been heard.

Again, the Woman's Auxiliary of the Mercer County Medical Society is to be thanked for their splendid cooperation in making this innovation a great success.

ANNUAL OUTING

OUR annual outing, held on June 18, 1953, at the Italian-American Sportsmen's Club, proved a very enjoyable affair, and gave the members an opportunity to escape their business cares for an afternoon of soft ball, quoits, and cards. All details were efficiently handled by the Entertainment Committee, under the chairmanship of Dr. Norman W. Garwood.

ANNUAL BANQUET

FORMER Governor Harold G. Hoffman was the guest speaker at our annual banquet, held at the Trenton Country Club November 19, 1953. A record attendance enjoyed the banquet.

HEADQUARTERS ROOM AT STATE SOCIETY
ANNUAL MEETING

ARRANGEMENTS are again being made for a "Mercer Society" room at the state society's annual meeting in May.

ALTERNATE SCIENTIFIC AND BUSINESS SESSIONS

DURING this administration, the policy of alternating scientific and business sessions was inaugurated, the purpose being to allow

sufficient time for our guest speakers to present their subjects at the scientific meetings, and to expedite the transaction of society business at meetings devoted exclusively to that purpose. Attendance records indicate a favorable reaction to this policy.

OSTEOPATHY AND MEDICINE

FOLLOWING a comprehensive presentation by Dr. Erwin P. Sacks-Wilner, chairman of the Legislative Committee of the Mercer County Medical Society, of the facts involved in the matter of osteopathy versus medicine, and after lengthy discussion at a meeting of the society, on March 10, our organization voted in favor of the Majority Report of the Reference Committee on Miscellaneous Business of the American Medical Association with respect to the classification of osteopathic practitioners.

FEE-SPLITTING

THE Mercer County Medical Society reaffirmed its opposition to a change in the present method of payments of fees by the Medical-Surgical Plan of New Jersey, whereby separate fees would be paid for pre- and post-operative medical services rendered by

others than the surgeon and for fees to be given for any assistance rendered the surgeon by the other physicians. In support of this attitude, a resolution was unanimously adopted at a regular meeting of our society on March 10 and submitted to the Board of Trustees.

ATTENDANCE RECORD

OUR society has adopted the policy of requesting all members attending meetings, to sign a registration book, and at the end of the year, an attendance record is published.

STATISTICS

TWENTY-NINE new members have been elected to membership during the past year; ten are serving with the armed forces; one has resigned because of change in place of practice and residence; six are pursuing postgraduate courses in the form of residencies; one was dropped from our "official list" because of non-payment of dues; and four have passed away, namely: Dr. William A. Chesner, August 27, 1953; Dr. J. N. Fuchs, December 10, 1953; Dr. J. Aaron Robinson, October 20, 1953; and Dr. John D. Rosso, March 25, 1954.

Middlesex

MALCOLM M. DUNHAM, M.D., President, Woodbridge

The following list enumerates the activities at the regular monthly meetings of the Middlesex County Medical Society.

January Meeting: "The Neuro-surgical Approach in the Treatment of Acute Cerebral Vascular Accidents," by Michael Scott, M.D., Professor of Neuro-Surgery, Temple University Medical School and Hospital, Philadelphia, Pa.

February Meeting: "The Adrenal Cortex: Clinical and Physiological Considerations," by Louis J. Soffer, M.D., Associate Attending Physician and Head of Endocrine Research Laboratory and Clinic, The Mt. Sinai Hospital, New York City.

March Meeting: "Newer Advances in Angiocardiology in Lung and Heart Disease," by Israel Steinberg, M.D., Assistant Professor of Medicine and Radiology, Cornell University Medical College.

April Meeting: "Rules of the Court as They Affect

the Medical Profession, and Other Pertinent Matters," by Francis M. Seaman, LL.B.

May Meeting: "The Cytologic Diagnosis of Cancer," by Locke L. Mackenzie, M.D., Associate Professor of Obstetrics and Gynecology, New York University Postgraduate Medical School. A 25-minute film on diagnosis of gastric carcinoma by cytologic means.

June Meeting: Social Outing with Dental Society—Golf and Dinner.

October Meeting: "Surgical Problems in Peptic Ulcer," by Ralph Colp, M.D., Clinical Professor of Surgery, College of Physicians and Surgeons, Columbia University.

November Meeting: "Modern Management of Rheumatic Arthritis," by Theodore B. Bayles, M.D., Visiting Physician and Director of Research, Robert Breck Brigham Hospital, Boston, Mass.

December Meeting: Annual Banquet and election of Officers. Guest Speaker: Dr. Houston Peterson, Professor of Philosophy, Rutgers University.

Monmouth

GEORGE J. McDONNELL, M.D., President, Freehold

SEVERAL developments and innovations occurred in Monmouth County in which this county medical society took part.

An Advisory Committee to the Monmouth County Organization for Social Service was created replacing the single adviser. This Committee consisted of an obstetrician, a pediatrician, a neuropsychiatrist, a radiologist, an orthopedist and an internist especially interested in chest diseases. The Committee stood ready with expert advice on pertinent problems at the frequent meetings that were held and time was saved in solving these problems to the satisfaction of both the Medical Society and M. C. O. S. S.

The School Physicians Committee has approved recommendations by the Monmouth County Health Officers Association that municipalities modernize and standardize isolation requirements for children convalescing from common contagious diseases.

The Society has approved the use of Salk polio vaccine for field trial in all second grades in this county and will provide physicians to give the estimated 15,000 intramuscular injections in addition to assisting in the public information aspects by making speeches, et cetera.

With the opening of a local TV station, the medical society was invited to provide medical programs. The invitation was accepted and to date several programs have been presented under the supervision of the Public Relations Committee.

MAIL balloting was used to determine the membership's attitude toward Social Security for physicians. Brief arguments for and against were included on the ballot. Results were:

For Social Security	38
Against Social Security	97
No response	111

Our membership increased from 246 to 256. One member died and six transferred to other societies during the year. Nine members are presently serving in military service and four returned during the past year.

The Public Relations Committee continued

its effort to inform the press and public on medical subjects of local interest.

The Emergency Medical Service has been continued as in previous years and has worked well despite some reluctance of some members to sign up and the mistaken impression of some of the public that this is a free service.

The Program Committee provided a number of fine speakers and symposia on timely subjects. The practice of holding one of our meetings at the Marlboro State Hospital was continued and was well attended. A joint dinner-meeting with the Dental Society and the Monmouth-Ocean County Pharmaceutical Society was again a feature for the fourth year with a large representative group in attendance.

The annual meeting with installation of officers was a dinner-meeting following the annual outing at which members displayed their skills at golf, soft ball, tennis and other entertainment. Attendance at this meeting improves each year.

THE social highlights of the Monmouth County Medical Society activities are the annual summer and winter dinner-dances presented by the Woman's Auxiliary and sponsored by the Society. Peak attendance was observed this year.

Since the Red Cross has abandoned its blood procurement program, the Society had placards made for display in members' offices and in the hospitals urging cooperation with the local blood banks.

Committees have been active in association and cooperation with various lay organizations interested in cancer, heart disease, polio, tuberculosis, et cetera.

A committee again read and reviewed fluorographic chest films of the school children of the county.

Many committees not mentioned functioned quietly and well while a few have been dormant because no occasion for their services occurred.

The executive committee devoted much time and energy to the welfare and efficiency of the Society and deserves a special commendation for its efforts.

FLOYD FORTUIN, M.D., President, Paterson

THE official 1953-54 year began with the second annual installation dinner, the success of which reflected the unsparing energetic work of the Dinner Committee and its chairman, Dr. John Ianacone, with Dr. Sandor Levinsohn as co-chairman.

Notable has been the response of the membership to the postgraduate education program, conducted by its active and resourceful committee headed by Dr. Wayne W. Hall. The scope of the educational efforts can be judged by the subject matter, which included courses in cardiology, proctology, detection and treatment of malignancies, and medico-legal problems. The courses were well attended for the most part and financially successful. The course on medico-legal problems was largely the effort of the Workmen's Compensation Committee headed by Dr. Joseph F. RuBacky.

The Committee on Cardiovascular Disease assisted the Post-Graduate Education Committee in advising and in obtaining speakers, many members taking an active part in the educational program of the Passaic County Heart Association.

High praise goes to Dr. John Ianacone and his Publication Committee, who with the able direction of our executive officer, Mr. H. Randall Norris, have published an informative and provocative "Bulletin" each month.

The Ethics Committee, after an initial spurt of energy last year resulting in the worthwhile Hospital Tissue Committee, proceeded more slowly with some of the vexing problems concerning fees.

Dr. Sandor Levinsohn and his Speakers Bureau Committee have contributed materially to the improvement of public relations in providing speakers for organizations.

Our executive officer caused unusual commendation from members of the press, and has done a notable task in obtaining their cooperation and good will. Under the auspices of the Public Relations Committee, headed by Dr. Leopold E. Thron, the Welfare Council in March had the pleasure of entertaining the press and informally discussing current medical problems. This led to a better mutual understanding.

WELL worked-out suggestions for improved hospital rehabilitation facilities came from the Committee on Crippled Children. The Committee on Diabetes and Nutrition did an excellent job during Diabetes Detection Week. The Committees on Conservation of Vision, and on Conservation of Hearing (particularly in industry) gave reports reflecting interest in a broader social point of view. The report of the Committee for the Study of Alcoholism had some very practical suggestions for better education of the public and hospital administrators. Likewise, the Pharmaceutical Relations Committee has been active in establishing better relationships with the druggists through a free aeration of mutual problems, resulting in several well-thought-out proposals. Dr. F. B. Brogan's Advisory Committee to Hope Dell, in a joint meeting of the Welfare Council and the Passaic County Board of Freeholders, has devoted much time and effort to clearing up a difficult situation.

The Woman's Auxiliary, under the competent presidency of Mrs. Paul Rauschenbach, is currently investigating an ambitious program of home-maker's care for the chronically ill. Such a program will relieve the hospitals of protracted care, be an invaluable aid in relieving the mental worries of patients unable to care for themselves and of course materially improve public relations. Essex and Union County have already achieved an acceptable solution of this problem.

In evaluating the work of the committees, to whose members and chairmen I express my unbounded appreciation, a few suggestions come to my mind. Regular meetings every one or two months at duly and early appointed days leads to most effective achievement.

IT is also fitting that the members of the Welfare Council receive commendation for their diligent attention to the problems of the society each month. Meetings now regularly take up a few hours, and most officers have duties that bring them weekly to the society building.

In conclusion, it would seem that the so-

ciety, acting through the small democratic units, the committees, has done a creditable job in recognizing its prerogatives in graduate education of its members, in improving its relations with the public by education, by better organization of its membership to fulfill the

needs of the public, and finally by correcting any abuses (fortunately rare) by the profession in its contacts with the public. Only by broadening the social objectives can the doctor hope to maintain his heritage of leadership in the community.

Union

WILLIAM H. MCCALLION, M.D., Elizabeth

THE Union County Medical Society celebrates its 85th anniversary this year. At the first regular meeting of the society held on June 2, 1869, fourteen physicians formed the membership. Today we have a membership of 537 active members and 11 emeritus members, a total of 547.

A Building Committee was appointed this year to study and bring in a report on the feasibility of acquiring permanent headquarters. One can see by the growth of the society in the past 85 years that many more projects could be carried out if we had the necessary space.

The Woman's Auxiliary is also increasing its membership in large numbers and would like to be able to hold its Board meetings in the Society's offices but we are unable to serve them due to lack of space. The attendance of the Auxiliary Board meetings is almost 100 per cent. Several organizations in health fields are very much interested in taking space with us. A central location is very important in order that all members may reach the office quickly and conveniently.

Our Speaker's Bureau has been very busy this year and the committee assisted in setting up a program with the Clark Adult Education Group. The first program has been so well received that they hope to put it on again next year with different medical topics.

Our Outing Committee this year provided an ideal place for us. Many of the men went fishing and others played golf at the Richmond County Country Club. The Club proved a delightful spot and the dinner was excellent.

THE Physicians Resources Committee had a very busy year as many questions and some problems arose regarding members called to

military service. The committee was most cooperative and all opinions were unanimous. Much time and thought were spent by members on their work and we feel that this committee rendered a fine service to the society. We have 16 members on active duty but are looking forward to the return of several by July.

The Advisory Committee to the Medical-Surgical Plan held a most informative meeting with representatives of one of our largest industrial plants to discuss mutual problems. The services available to the employees and fee schedules were discussed and many questions clarified.

The enrollment of over 300 members in the Hospital Service Plan of New Jersey has created a department of its own as every month finds changes in the status of members which must be reported. Sometimes members forget to notify the office of a marriage, birth or death. The Insurance Committee has been most helpful in helping members with questions that arise from time to time in regard to their policies.

THE Mental Hygiene Committee has cooperated with Union County, New Jersey Association for Mental Health, Inc., in an advisory capacity when called upon. The two groups gave a most interesting and informative program at the March meeting of the society. Mrs. A. F. Ackerman, president of this corporation, spoke briefly on the services made available by her organization; members of the Committee discussed the facilities available in the county.

The Judicial Committee held several meetings during the year and handled all cases satisfactorily. All applications for membership

are considered by the committee and it feels that the new plan of having applicants present at a meeting with their sponsors is good.

We are very proud of our woman's auxiliary. They are growing in numbers and in the fine programs they are giving. The Homemakers Service of eastern Union County is now in its second year of service and has gained national recognition for the Auxiliary. The scholarship for student nurses is continuing and one of the graduates of recent years is now a member of the faculty of the nurses' training school at the Elizabeth General Hospital.

THE Public Relations Committee has had an active year. A dinner meeting was arranged with representatives of several newspapers in the area and it was a most enlightening and interesting meeting. One of the results of the meeting was an offer from the Elizabeth Daily Journal to accept articles written by our members for weekly publication. A meeting of the Public Relations and Public Health Committees was held and preparations made to have our members participate in this program.

The Public Health, Public Relations and Emergency Committees have worked very closely, particularly on the problem of emergency medical service. For some time we have felt that while we are rendering service, the old plan needed reorganization. Members of the society were circularized again (as they were five years ago) but this time doctors serving will do so on a panel basis. All new members are expected to take their place on the panel and their response was most gratifying. Every town has its own panel and every doctor will receive notice one month before the day he is expected to serve. We also now have an advertisement in the classified section of the Elizabeth and Plainfield telephone books under the section "Physicians and Surgeons," notifying the public that emergency medical service is available by the society for those who do not have a family physician or who are unable to reach their own physician.

THE Cardiac Committee are also members of the Board of Trustees of the Union County Heart Association. A very fine program was

provided in February on hypertension with doctors coming from all parts of the county. This is the first of many such programs that the Cardiac Committee, in cooperation with the Heart Association, will present for professional education.

A new fee schedule which permits an increase to all doctors taking care of clients of the Union County Welfare Board has been granted due to the work of the Advisory Committee to the Board and the Director of the Board who has worked very closely with the committee on this project.

The Program Committee again this year provided outstanding speakers on topics of great interest to the members. Two of the programs were provided by our own members of the Mental Hygiene Committee and the Cancer Committee.

The chairman of our Legislative Committee is also a member of the State Committee on Legislation. Thus, we are kept well informed on all legislative matters of interest to the medical profession and we are alerted whenever there is need for action on the part of the society.

The executive office moved to larger quarters last summer and already we need more space! In the fifteen years that the society has maintained headquarters, the office has had to move four times due to the increase in our membership and the work entailed. Our office is proving not only an information center on medical services in our own county, but calls come through from other counties and even other states. We are always glad to render service to any one when we can.

WE REGRET that it is not possible to enumerate every committee that worked hard and earnestly on all programs and projects submitted to them but we can express our appreciation to every member who participated. The executive committee meetings were well attended and members most cooperative in carrying out the work of the society this year.

Again we will have our own headquarters at the annual meeting of the state society and we are very proud that Dr. Elton W. Lance, a member of our society, will be the next president of The Medical Society of New Jersey.

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The Problem of Tuberculosis in Psychotics

By Abraham M. Balter, M.D., Michael Pilpel, M.D., Harold S. Hatch, M.D., and George N. J. Sommer, Jr., M.D., *The American Review of Tuberculosis*, November, 1953.

Case finding of active tuberculosis is at such a high level of efficiency in this country that it can well be asked why we allow a dangerous focus of tuberculosis infection to go inadequately explored and reluctantly treated.

This focus comprises the patients who are hospitalized in institutions for the mentally ill. The danger of exposure of psychotic patients to tubercle bacilli is serious and its importance to society is but dimly realized. It is near to absurdity to make great effort to find tuberculosis in the general population and to ignore it in the psychotics. The number of tuberculous patients varies with different institutions, but, on the whole, it is much higher than in the general population. Various theories are offered to account for this increased incidence: that the psychotic undergoes some kind of metabolic change in which a failure of resistance renders him an easy victim of the disease; that the psychosis causes a person to eat poorly, to become dilapidated, and to be careless of himself; or that he is in intimate contact with undiscovered cases of active tuberculosis. Probably all factors are active. Whatever the reason, the incidence of tuberculosis is greatest in those patients who have been hospitalized for five years or more.

When the psychotic is identified and placed in an institution, he is too often dismissed from mind. The psychotic himself has withdrawn from the world of reality and from acceptable human ac-

tivity. But the phthisiologist may not withdraw from the vexatious reality presented by the tuberculous psychotic. Hopelessness has no place in the treatment of mental illness. Psychotics can and frequently do recover; and, having recovered, they are at a grievous disadvantage if they must be hospitalized for the tuberculosis which they acquired while under treatment for the psychosis.

Every form of diagnostic procedure should be carried out with psychotic patients. Whether it is sputum collection, extraction of gastric contents, roentgenograms of the chest, planigrams, fluoroscopy or bronchoscopy, it can be done. Free use of sedation may be employed successfully with any diagnostic procedure. The patient must never be allowed to order his own regimen by defeating the efforts of his physician.

There are no statistics regarding the difference in infectiousness between the psychotic tuberculous patients and the nonpsychotic. The impression, however, is that the former are more infectious because many are dilapidated; and to discover them is both difficult and time consuming. Tuberculosis can make great advances between yearly roentgenograms.

Our impression of the course of tuberculosis in the mentally ill cannot as yet be reinforced by statistical data. There has been an impression, however, that tuberculosis in the mentally ill is more indolent, less responsive to treatment, and is more prone to relapse. Whether this would be true if tuberculous psychotics could be treated under ideal conditions, is uncertain; but our results indicate that the course of tuberculosis in the mentally ill relates directly to the care and attention given to prevention and treatment.

The history of illness given by a psychotic may be surprisingly accurate, or it may be misleading, irrelevant, and absurd; or there may be no history at all. Diagnosis must often depend on factors other than the history. The physician must maintain a high "index of suspicion" for the disease, and all personnel must be thoroughly indoctrinated to watch for changes of attitude and behavior in patients. If the physician is alert to the valuable information brought to him by nurses, aides, and others who come in contact with patients, he will be quick to order the roentgenogram. Diagnostic methods should then be followed as closely as with nonpsychotics. The patient may not be cooperative but, with persuasion, gentle handling, and with proper sedation and timing, the desired film can be obtained. Patients vary in their mood, and there are frequent intervals when they are cooperative. Refusal to eat is a frequent occurrence among psychotics. The resulting loss of weight should be a warning signal to the physician.

The problems presented in the treatment of tuberculous psychotics resemble those of diagnosis, but the difficulties are greater. The patterns of treatment for the psychotic must be the same as those for the nonpsychotic.

Rest is still the basis of treatment. Great care is taken to teach all patients the rest regimen, although many patients require longer and more persistent training. Among these will be a minimum who will break treatment no matter how carefully taught and how closely watched. How large this irreducible minimum is will vary with the tolerance of the personnel to breaks in treatment. An energetic, well-trained, and careful group will have only a small number of uncooperative patients.

It is reasonable to ask what may be done with a patient who is overactive, resistive, assaultive, and not amenable to persuasion, but who has far advanced tuberculosis with a sputum rich in tubercle bacilli. Treatment then becomes a joint matter between the phthisiologist and the psychiatrist. Shock therapy and lobotomy may be in

order and, if so, can be carried out as with the nontuberculous psychotics. These are instances where the psychosis is the disease of greatest urgency, but, when the patient becomes more amenable to the hospital regimen, tuberculosis once again becomes the more important problem. These patients require much more care and attention than either the nonpsychotic tuberculous or the non-tuberculous psychotic.

Where the indications are good, a combination of surgical procedures with antimicrobial therapy is the method of choice. Thoracoplasty, lobectomy, segmental and wedge resections are carried out exactly as with nonpsychotics.

In addition, a great deal may be expected from extensive employment of streptomycin with para-aminosalicylic acid or with isoniazid. Minimal and moderately advanced cases show a surprising response and the more advanced cases may be improved to a degree where surgical procedures become possible. Patient cooperation can be a problem in antimicrobial therapy. Ordinarily, para-aminosalicylic acid or isoniazid by mouth and the injection of streptomycin are accepted by psychotics with as little resistance as by nonpsychotics. Sometimes much persuasion is necessary, and occasionally a patient must be held while he receives his injection, and the oral medication must be given in soluble form mixed with food. With a stable group of patients who may not leave the hospital at will, it is possible to apply all methods of treatment as they are indicated.

Originally, our efforts began with systematic case finding and continuous re-examination of our tuberculous patients, both active and inactive, and regular follow-up of all personnel. Patients were systematically trained to follow the rest regimen; collapse therapy was employed whenever indicated. The current regimen of streptomycin combined with para-aminosalicylic acid and isoniazid, has given gratifying results. With vigorous application of all methods of therapy the whole patient, with his tuberculosis and psychosis, can be treated successfully and tuberculosis in a neuropsychiatric institution can be controlled.

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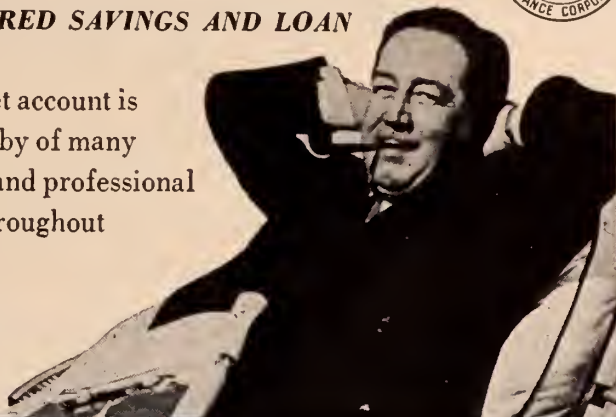
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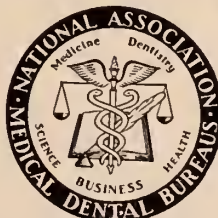
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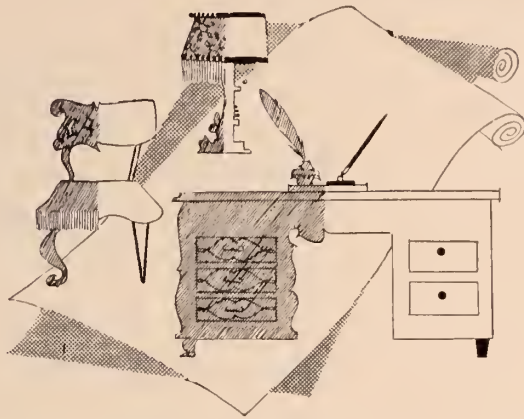
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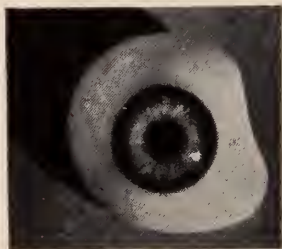
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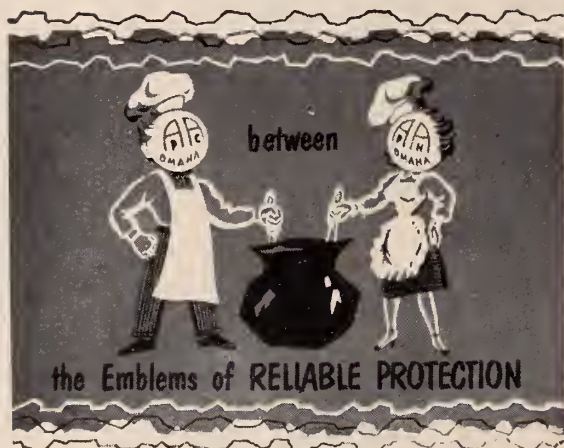
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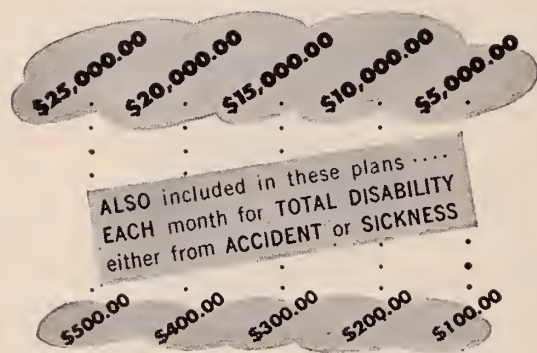
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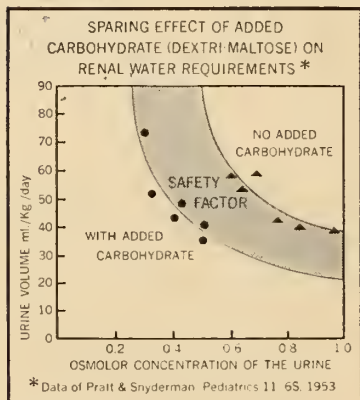
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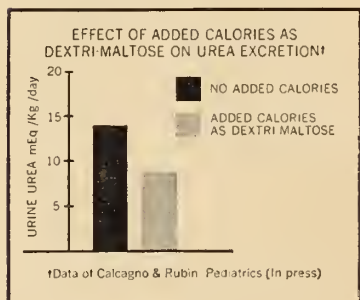
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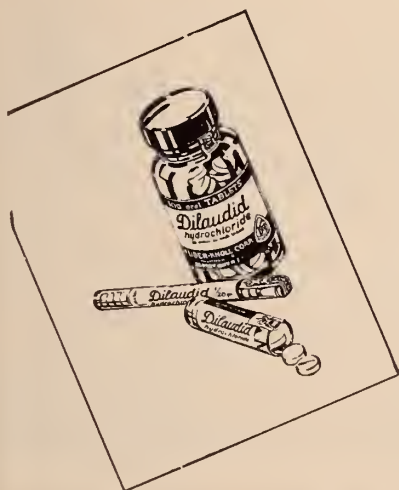
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Powerful opiate analgesic - dose, 1/32 grain to 1/20 grain.

Potent cough sedative - dose, 1/128 grain to 1/64 grain.

Readily soluble, quick acting.

Side effects, such as nausea and constipation, seem less likely to occur.

An opiate, has addictive properties.

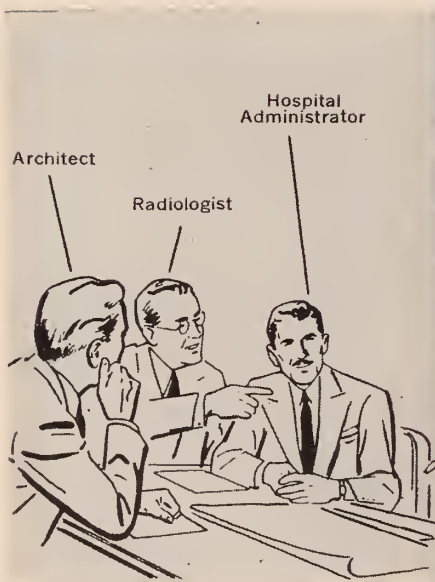
Dependable for relief of pain and cough, not administered for hypnosis.

● Dilaudid is subject to Federal narcotic regulations. Dilaudid, Trade Mark Bilhuber.

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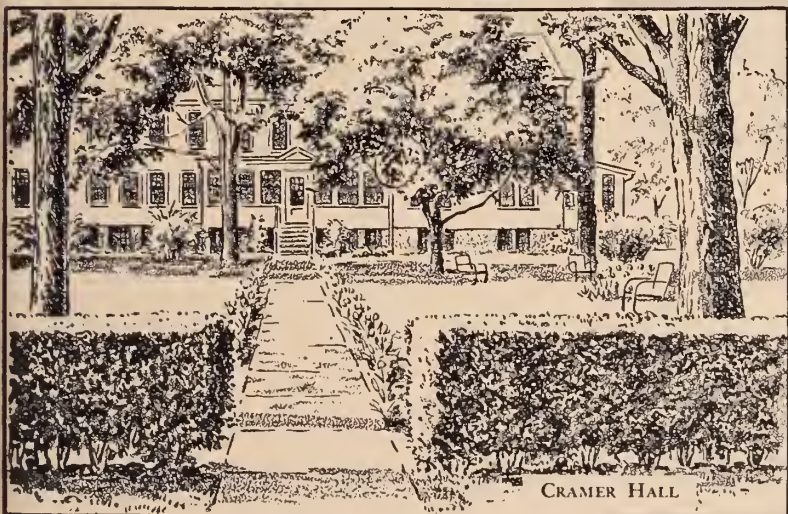
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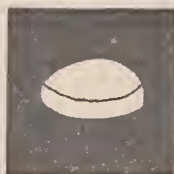
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"The routine Benedict test...is seldom well performed because of the difficulties of accurate measurement of reagent and urine and because of the practical difficulties of uniform heating; the much simpler and more readily standardized tablet test is to be preferred..."²



1. Cook, M. H.; Free, A. H., and Giordano, A. S.: *Am. J. M. Technol.* 19:283, 1953.

2. Gray, C. H., and Millar, H. R.: *Brit. M. J.* 4824:1361 (June 20) 1953.

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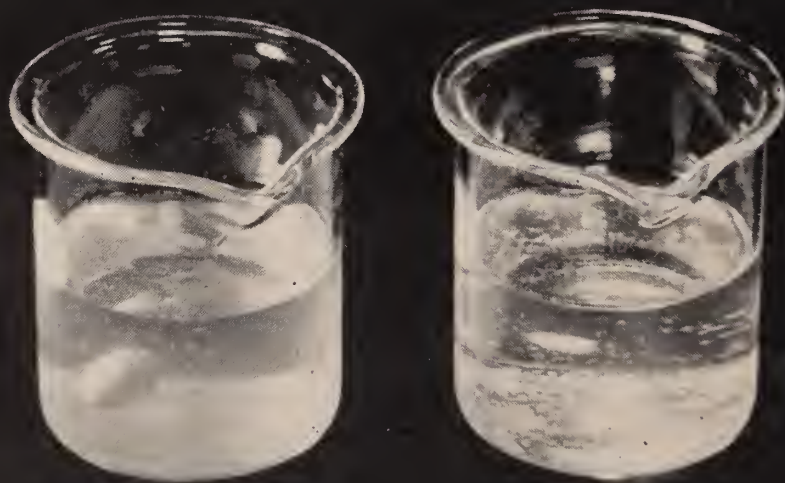
1. Thorn, G. W., *et al.*, *New England J. Med.* **248**:632, April 9, 1953.

SUPPLIED: ORAL—HYDROCORTONE Tablets: 20 mg., bottles of 25 tablets; 10 mg., bottles of 50 and 100 tablets; 5 mg., bottles of 50 tablets.

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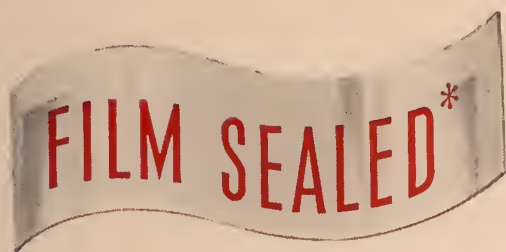


here's why your patient gets



3:15—Disintegration Test begins in actual stomach fluids (pH 2.7). Beaker at left contains ordinary enteric-coated erythromycin. At right is new Film Sealed ERYTHROCIN Stearate (Erythromycin Stearate, Abbott).

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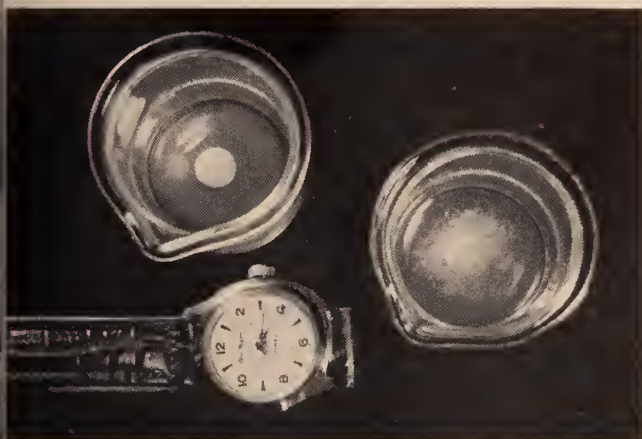


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HIGH BLOOD CONCENTRATIONS WITHIN 2 HOURS



3:20—Five minutes later, *Film Sealed* coating has already started to disintegrate. The tissue-thin film actually begins to dissolve within 30 seconds after patient swallows tablet.



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3:45—Now the *Film Sealed* tablet mushrooms out with all of the drug available for absorption. Note that enteric-coated tablet is still intact. Tests show that the new Stearate form definitely protects ERYTHROCIN against gastric acids.



4:00—Because of *Film Sealing* (marketed only by Abbott) the drug is released faster, absorbed sooner. In the body, effective ERYTHROCIN blood levels now appear in *less than 2 hours* (instead of 4-6 hours as before). *Abbott*

WHEN SYMPTOMS ARE DISTRESSING BUT DISGUISED . . .

"It is strange," Malleson says, "how little clinical recognition" has been given to the "negative behavior" or "endogenous misery" of the woman with endocrine imbalance. Largely accountable for this, of course, is the patient's own reluctance to discuss these symptoms with her physician until she actually suffers from some of the more obvious menopausal symptoms such as hot flushes. Even then she may become so accustomed to her change in feeling she can't remember what it's like to feel well.¹

Changes in the mood pattern are just a few of the many distressing symptoms of declining ovarian function which are so often disguised because they do not always coincide with cessation of menstruation, and at times will occur long before, and even years after. Other good examples are insomnia, headache, easy fatigability, arthralgia — and understandably so, when one considers that the loss of ovarian hormone "withdraws one of the most important metabolic regulators of the organism."²

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1. Malleson, J.: Lancet 2:158 (July 25) 1953. 2. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc. 1953, p. 23.

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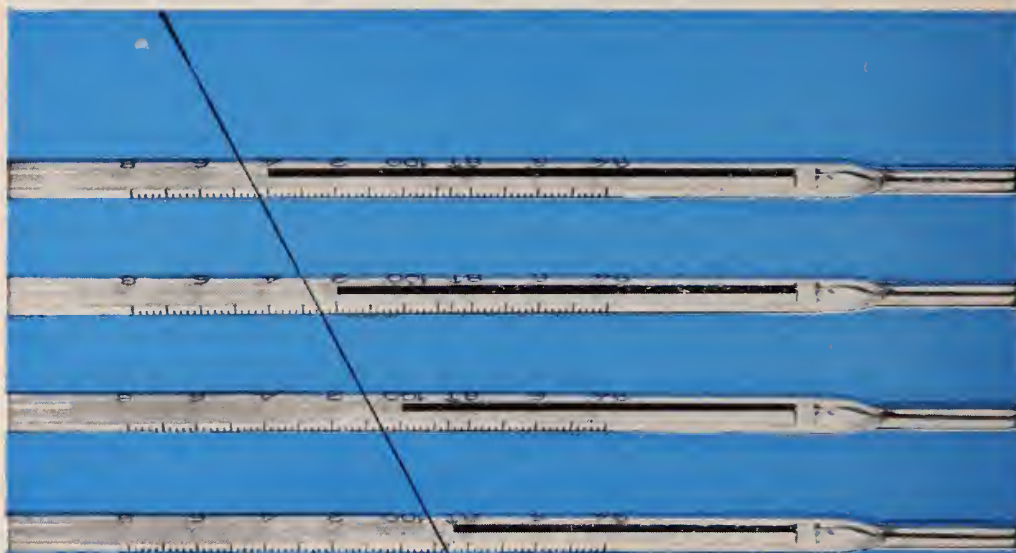
Write for pad of diet sheets.

1. Heller, E. M.: The Treatment of Essential
Hypertension. *Canad. Med. Assn.
Jour.*, 61:293, Sept., 1949.

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English, A. R., et al.: Antibiotics Annual (1953-1954),
New York, Medical Encyclopedia, Inc., 1953, p. 70.

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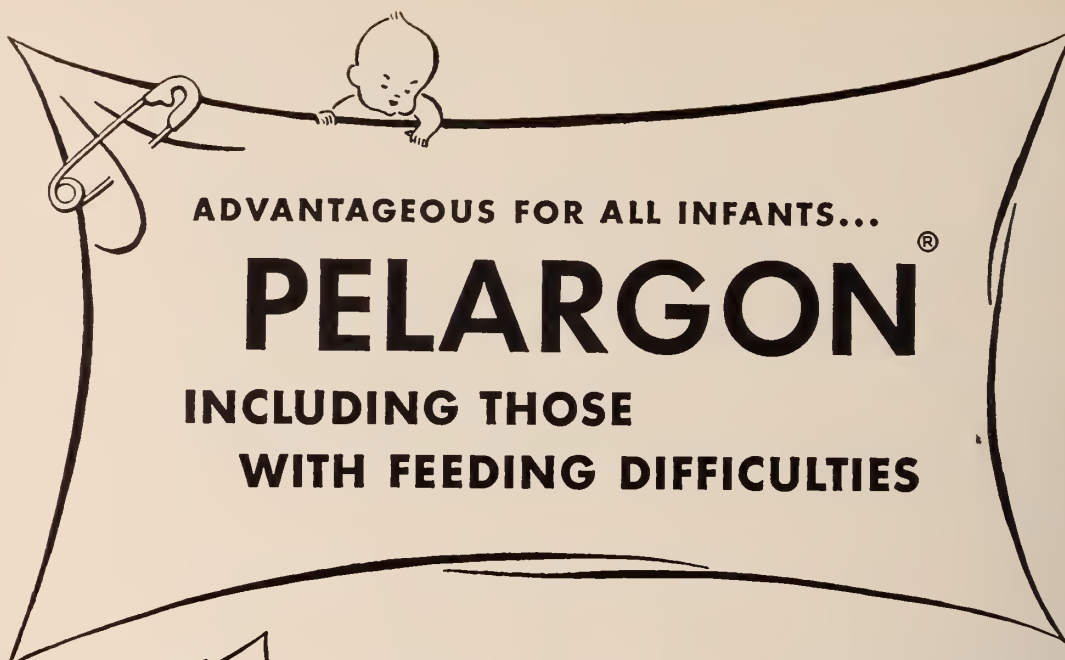
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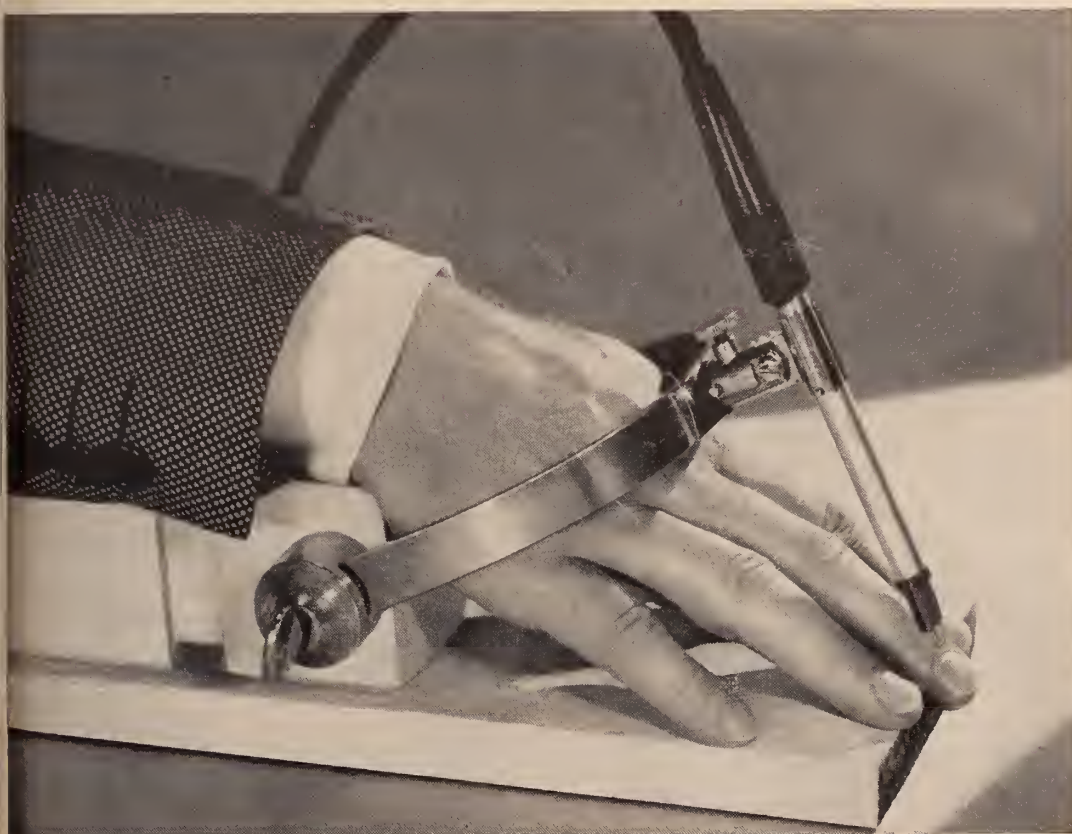
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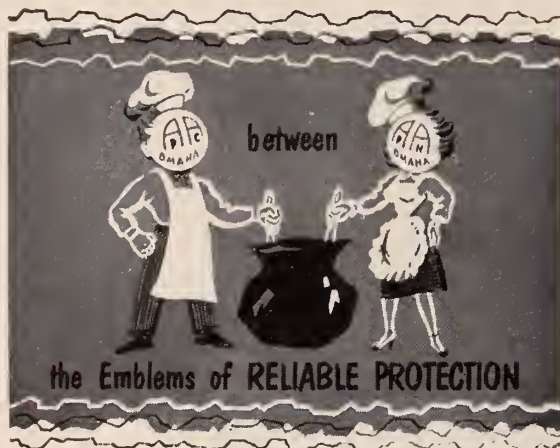
Thus KENT, with the first filter that really works, gives the one smoker out of every three who is susceptible to nicotine and tars the protection he needs . . . while offering the satisfaction he expects of fine tobacco.

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If you have yet to try the new KENT with the exclusive Micronite Filter, may we suggest you do so soon?

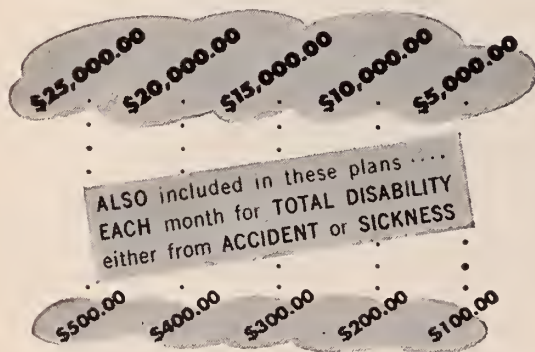


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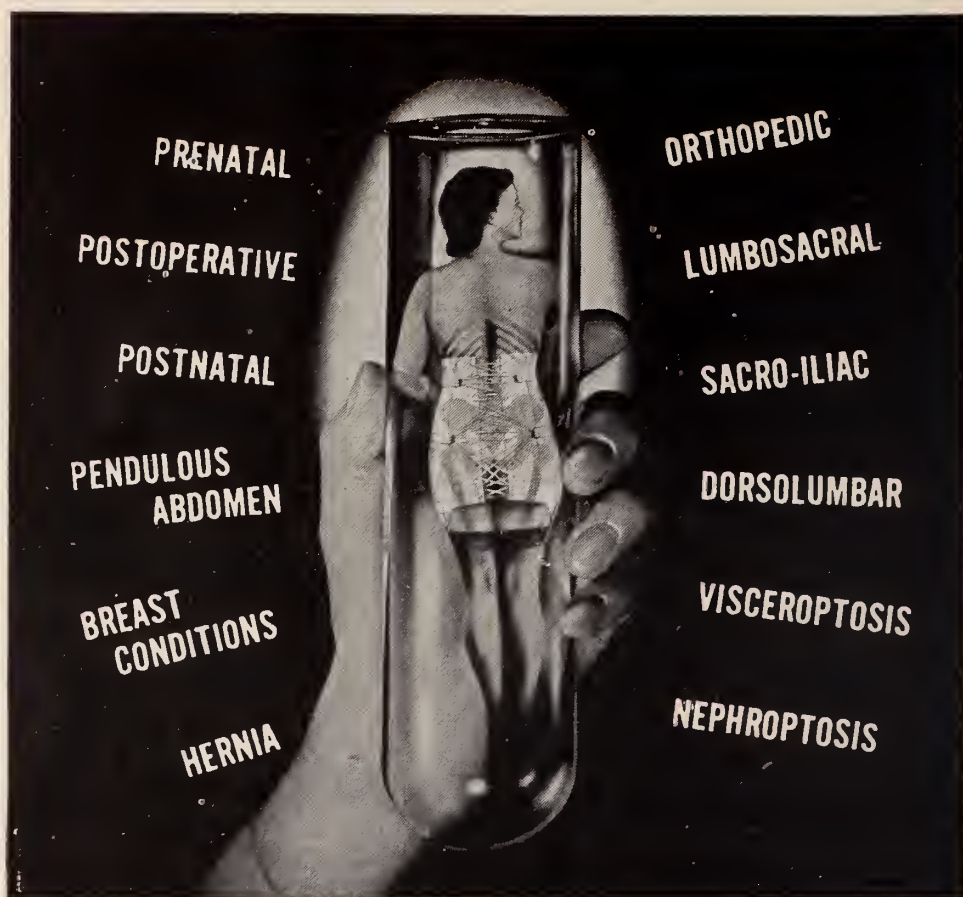


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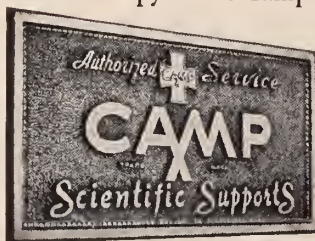


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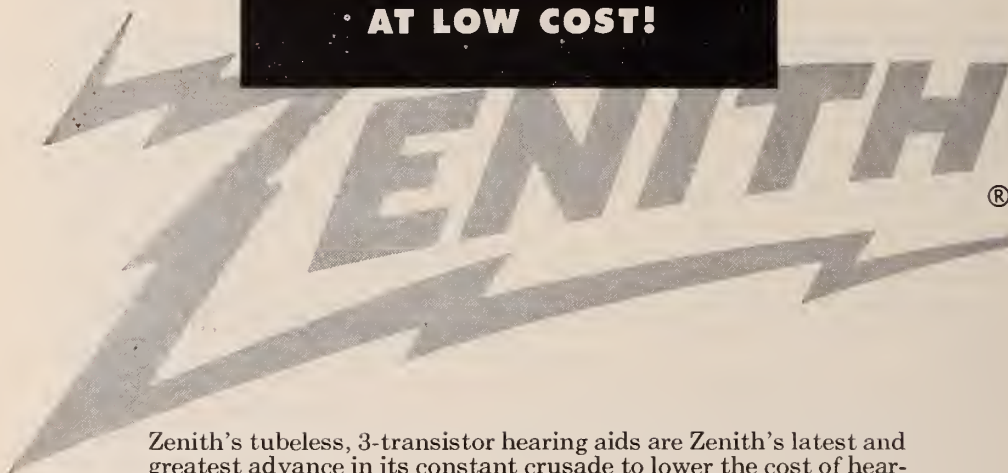
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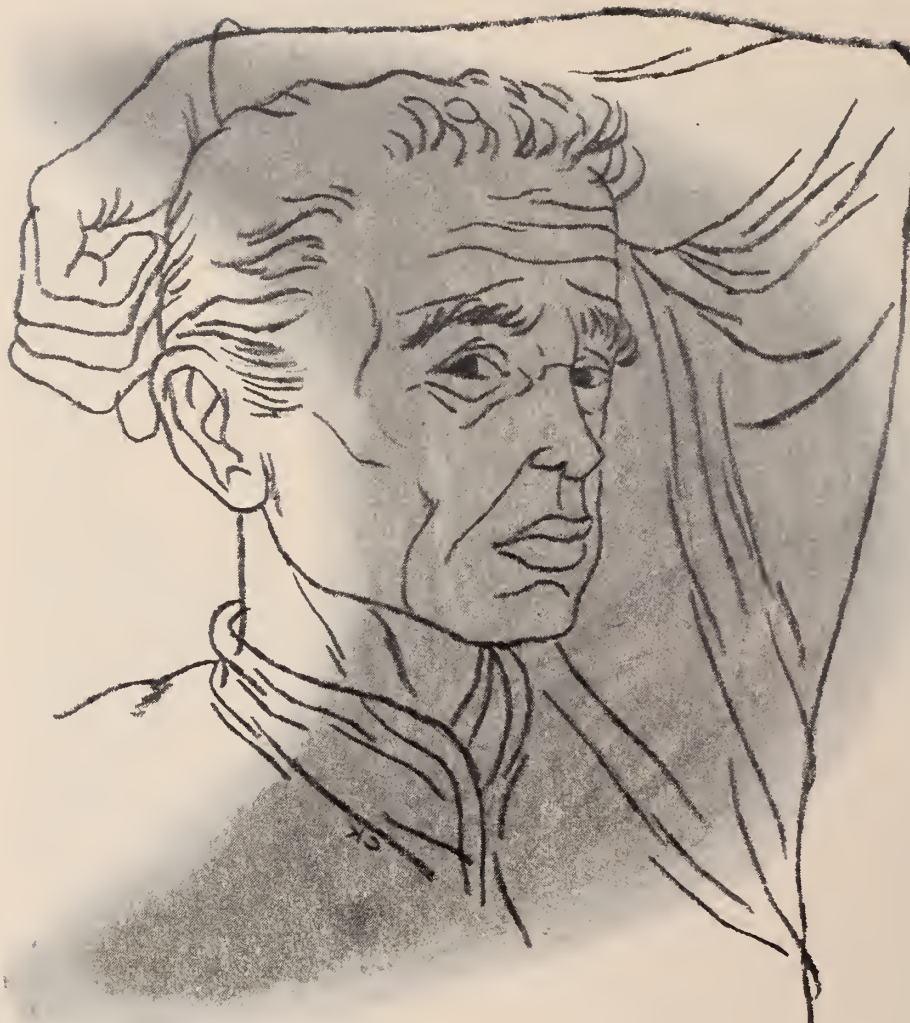
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1. Gurdjian, E. S., and Webster, J. E., *Amer. J. of Surgery*, 63:236, 1944.

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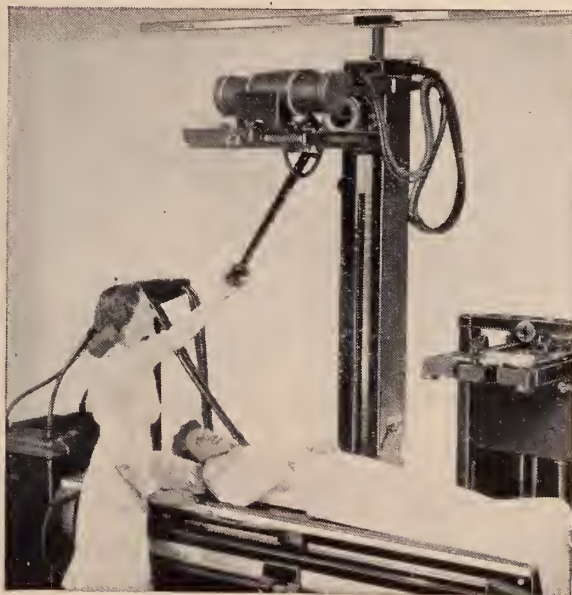
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1. Moyer, J. H.; Miller, S. I., and Ford, R. V.: J.A.M.A. 152:1121 (July 18) 1953.

2. Moyer, J. H.; Snyder, H. B.; Johnson, I.; Mills, L. C., and Miller, S. I.: Am. J. M. Sc. 225:379 (April) 1953.

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Editorials • • •

Elton W. Lance, M.D., 1954-1955 President

A native New Englander, Dr. Elton W. Lance, the new President of The Medical Society of New Jersey, was born in Cabot, Vermont. He attended Lebanon High School, Lebanon, New Hampshire and was graduated from Montpelier Seminary, Vermont in 1918. He received his undergraduate training at the University of Vermont and his medical degree from the same university. Following an internship at Mary Fletcher Hospital in Burlington, Vermont, Dr. Lance began his practice in Rahway, New Jersey, in October 1925. Since 1935 he has specialized in general surgery.

During World War I Dr. Lance served in the S.A.T.C. from 1918 to 1919. He held a commission as first lieutenant in the Medical Officers Reserve Corps from 1925 until 1935.

World War II found Dr. Lance in the Medical Corps of the Army of the United States as



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a major. For twenty-eight months he was in the European theatre (Iceland Base Command). During this period he was chief of surgery and executive officer of the Fortyninth Station Hospital. In July 1943 he was promoted to lieutenant colonel and made commanding officer of the Fourteenth and later the Ninety-second Station Hospital. Upon his return to the United States he was assigned to the 1234th Service Command Unit, Convalescent Hospital, Camp Upton, New York. There he was chief of the infirmary division and later chief of the reconditioning division.

Dr. Lance has been a member of the staff of Rahway Hospital since January 1926, where he has served as pathologist, attending obstetrician and attending surgeon. He has been president of the hospital staff and chairman of the executive committee for several years.

In 1946-1947 Dr. Lance was president of the Union County Medical Society. He has been a member of the public health committee and a delegate to the state medical convention for several years.

Dr. Lance was elected to the board of trustees of The Medical Society of New Jersey in 1946 and was its secretary from 1948 to 1951.

In 1936 and 1937 Dr. Lance served on a fact finding committee of the state medical society in relation to voluntary health insurance. In 1937 he became chairman of the committee on voluntary health insurance. This committee later became the founding committee of the

Medical Service Administration and the Medical-Surgical Plan of New Jersey. Dr. Lance served as the first president of these two medical care groups and served as such until June 1942 when he resigned to enter military service.

Following Dr. Lance's return from the Army in 1946, he became a trustee of both the Medical Service Administration and the Medical-Surgical Plan.

Dr. Lance is a member of the Academy of Medicine of New Jersey, of the Society of Surgeons of New Jersey, and a fellow of the American College of Surgeons.

In spite of his numerous medical society activities and an active practice, Dr. Lance has always been interested in church and civic affairs. For nine years he served as a member of the Board of Health of Rahway and has been school physician of that community since 1927.

Dr. Lance is married and has two sons, Edward Merriman, a graduate of Johns Hopkins University Medical School, now serving in the Navy and Kendrick Paige, a graduate of Harvard Medical School, also presently in the Navy. Dr. Lance's hobbies include early Americana and collecting recorded music. To round out this picture of the "complete physician," Dr. Lance is also an ardent fisherman.

We are happy to have such an energetic and enthusiastic President for the coming year and we welcome him to his position of honor and responsibility.

Clinics for Chronic Alcoholism

Aggravation is usually the lot of the physician who cares for chronic alcoholics. Such patients are often uncooperative, abusive, and inconsiderate. When inebriated they are likely to call the physician as whimsy dictates. In addition, management of these patients for medical or surgical conditions is frequently complicated by the chronic alcoholism itself. The association of alcoholism with cirrhosis of the

liver, pulmonary tuberculosis, and an increased incidence of pneumonia, syphilis, accidents and criminal activities is well known.

The enormity of this problem is appreciated throughout the country. New Jersey has recognized its responsibility in regard to these patients and, with the assistance of the New Jersey State Department of Health, study clinics have been set up in St. Michael's Hospital,

Newark; West Jersey Hospital, Camden; and William McKinley Memorial Hospital, Trenton.

The purpose and organization of the last named clinic has been described recently in the bulletin of the Mercer County Medical Society.* Problem drinkers who desire treatment in this clinic are first given a complete medical work-up including basic laboratory studies and any indicated additional tests. Medical, surgical and psychiatric consultations are readily available. A report of the diagnosis and treatment plan is sent to the referring physician. Once diagnosis of problem drinking is made, the patient is scheduled for regular appointments, usually weekly, and treatment is started.

For any other medical or surgical condition the patient is referred back to his private physician, who is always kept advised of the patient's progress with regard to alcoholism.

These study clinics are particularly designed for those drinkers who sincerely desire to end their alcoholism and recognize the need for undergoing treatment which aims at permanent sobriety.

The establishment of these clinics is an important step forward in combating this widespread and unhappy disease.

*Bulletin of the Mercer County Medical Society: Study Clinic at William McKinley Memorial Hospital, Trenton. Page 2, February 1954.

Rheumatic Heart Disease Surgery

One of the most brilliant advances in recent years has been the development of surgical procedures for the correction of valvular deformities due to rheumatic heart disease. After early halting exploratory steps, Bailey and his co-workers at Hahnemann Hospital perfected the technic of mitral commissurotomy and have performed it on several hundred patients. Cardiologists and surgeons throughout the country have followed his example and undoubtedly there are now thousands of patients with mitral stenosis whose lot has been bettered by this operation.

As with previous advances in medical history, however, a wave of enthusiasm is followed by one of doubt and final evaluation awaits the passage of time. With a disease the course of which is as variable and unpredictable as rheumatic heart disease it is even more difficult to weigh the pros and cons of any therapeutic procedure and to determine what is best for each individual patient. Many patients with mitral stenosis live to an advanced age apparently untroubled by the alterations in cardiac function produced by this lesion. On the other hand, a sizable percentage of mitral stenosis patients succumb at an early age in spite of the most intensive medical therapy. It has only

been possible in the past few years to enumerate the indications and contra-indications for mitral commissurotomy.

Soloff¹ and his colleagues have recently described a further note of caution in the application of this operation. In a group of consecutive individuals subjected to mitral commissurotomy a febrile syndrome occurred in forty-three (24%). This syndrome was characterized by a combination of events occurring after a variable period following the operation. It was marked by precordial pain and fever and frequently associated with precipitation or intensification of heart failure. At times there are migratory joint pains, arrhythmias, hemoptysis, psychoses and, on rare occasions, death. After a careful study of their material these authors concluded that this syndrome represents a reactivation of rheumatic fever.

The effect of this post-commissurotomy reactivation of rheumatic fever on the ultimate beneficial results of such surgery remains to be seen. Yet the awareness that such reactivation may occur following surgery must be considered in the determination of the advisability of such an operation for any given patient.

1. Soloff, L. A., *et al.*: Reactivation of Rheumatic Fever Following Mitral Commissurotomy. *Circ.* 8:481, October, 1953.

N. J. Neuro-Psychiatric Institute Now Receiving Patients

New Jersey practitioners are notified that there is now available at Princeton, the New Jersey Neuro-Psychiatric Institute, a state-operated intensive-treatment hospital for certain neurologic and psychiatric disorders. The Institute emphasizes research and training as well as treatment. Dr. Nolan D. C. Lewis, long a pioneer in neurologic and psychiatric research is director of the research program, and Dr. Robert S. Garber is superintendent of the Institute. Dr. Lewis is heading up a neurologic and psychiatric research program which integrates all neuropsychiatric research in the state's public hospitals.

Two categories of patients are now being received, and other categories will be admitted as soon as beds are available and a staff recruited. Already entering are psychotic children and epileptics of all ages. Children with primary behavior disorders are usually sent to the Child Treatment Center at Allaire while the child who is frankly psychotic is more appropriate for the Neuro-Psychiatric Institute. However, most children are first seen at the Diagnostic Center (Menlo Park) for classification and then transferred either to Princeton or Allaire. If you have an emotionally disturbed young patient, write to the Institute* for forms.

* Write to: Superintendent, N. J. Neuro-Psychiatric Institute, Box 1000, Princeton, N. J. and ask for a commitment paper and voluntary admission form. If the patient's parent (or guardian) is willing to place the child, the voluntary form is used. Otherwise the commitment paper is prepared. Return the filled-out form (no court order is necessary) to the Bureau of Mental Deficiency, Department of Institutions and Agencies, Trenton 7, and you will be advised of the next step.

Epileptics of all ages are admitted subject to three contingencies: (a) they must have normal intelligence; (b) they must *not* be psychotic; and (c) they must have been treated vigorously but unsuccessfully with anticonvulsant drugs on an outpatient or private patient status. If you have an epileptic who meets these criteria, write to Princeton* and obtain the voluntary admission form, if the patient (or his parent, if the patient is a child) is willing to enter the Institute.

As more staff is recruited and more buildings are opened, the following categories will be admitted: alcoholics, multiple sclerosis cases, cerebral palsy patients, chronic neurologic disorders generally, drug addicts, and sexual deviates. At present none of these can be received, and when provision has been made for the reception of such patients, doctors of New Jersey will be notified through the pages of this JOURNAL.

The Institute is an intensive *treatment* center which will employ all the modern modalities of treatment both in psychiatry and neurology. It is already training residents in both specialties in affiliation with the Jefferson Medical College and the University of Pennsylvania. Practitioners of this state who have young physician-friends interested in either neurology or psychiatry may obtain more details about the training program from the Superintendent of the New Jersey Neuro-Psychiatric Institute, Box 1000, Princeton, N. J.

IRVING L. SPERLING, M.D.

Newark

Joint Manifestations of the Collagen Diseases*

The collagen diseases are rare but important ones requiring astute diagnostic acumen. Many have joint symptoms which cause confusion with true arthritides. Their differential diagnosis is clearly described.

COLLAGEN diseases are fairly rare, but occur frequently enough to cause difficulties in differentiation from the rheumatic diseases. This differentiation is important for two reasons: 1) Prognosis—collagen diseases bear a serious outlook and are frequently fatal. Rheumatic diseases carry a high morbidity but low mortality. 2) Therapy—this is chiefly important as it relates to prognosis. Certain forms of treatment indicated in rheumatic diseases are contraindicated in the collagen group. For example, gold, fever therapy, ultra-violet and x-ray therapy are used in rheumatoid arthritis but may cause serious flare-ups of the collagen group.

The problem of diagnosis is complex and at times the two groups cannot be differentiated until after a prolonged period of observation. Joint manifestations are common to both. Although joint symptoms are frequent in collagen diseases they have not been stressed enough and are not clearly understood as a diagnostic point. This paper outlines the types of joint involvement in the collagen diseases and stresses their diagnostic import.

There has been an attempt to differentiate the two groups by categorizing their joint manifestations as follows: 1) Rheumatic — easier and more definite diagnosis with less serious prognosis. 2) Para-rheumatic—neuromuscu-

lar manifestations of the collagen group of more serious prognosis. This is primarily an arthropathy rather than true joint inflammation.

Steinbrocker¹ recently attempted to divide these groups on the basis of the following clinical manifestations: 1) Myalgias and arthralgias—fibrositic type. 2) Acute and sub-acute polyarthritis—rheumatic type. 3) Chronic progressive, diffuse polyarthritis—rheumatoid arthritis type.

Collagen diseases may fit into the above categories but are more often atypical.

CLASSIFICATION

COLLAGEN diseases comprise a group with diverse clinical manifestations and similar connective tissue changes. The term "diffuse collagen disease" was introduced in 1945 by Klemperer, Baehr and Pollack² to include these diseases with so-called "fibrinoid degeneration."

The chief tissue alterations are in the collagen or intercellular ground substance of connective tissue. These include changes which show microscopic granular aberrations staining pink with eosin and resembling fibrin—thus a fibrinoid degeneration. There is also

* Presented before the Section on Rheumatism at the Annual Meeting of The Medical Society of New Jersey in Atlantic City on May 18, 1953.

proliferation of connective tissue and infiltration of leucocytes. The arteries and vein walls are also involved by the process of degeneration, proliferation, and inflammatory changes.

The diseases included in this group are:

1. Periarteritis nodosa
2. Disseminated lupus erythematosus
3. Scleroderma
4. Dermatomyositis
5. Rheumatic fever
6. Rheumatoid arthritis.

In addition to this group the following are sometimes included as belonging to or related to the collagen diseases:

7. Serum sickness
8. Calcinosis
9. Erythema nodosum
10. Anaphylactoid purpura (Henoch's and Schonlein's)
11. Erythema multiforme
12. Thromboangiitis obliterans
13. Loeffler's pneumonia.

THE etiology of these diseases is unknown, but recent work points to possible hypersensitivity. Rich³ has produced clinical and experimental evidence of hypersensitivity to bacterial and other foreign proteins.

Lesions of periarteritis nodosa and rheumatic fever have been produced in rabbits by horse serum injections. Hypersensitivity to sulfonamides, aspirin, iodides, thiourea, Dilantin,[®] etc., produces lesions like periarteritis nodosa.

Others claim that collagen diseases are an acceleration of the normal aging process, and that this may be selective or generalized, resulting in varying clinical manifestations.

Klinge, in 1929, claimed rheumatic fever and rheumatoid arthritis are diseases of interfibrillar substances with secondary changes in the cells.

Theoretically we have a common lesion in collagen diseases, related to hyaline and osteoid tissue. The basic cells (fibroblasts, chondroblasts, and osteoblasts) are all derivatives of the same stem—mesenchyme. Also the reticulo-endothelial system contains cells of mesenchymal origin. The basic function of reticulum and mesenchyme may be defense. Excessive response of these two systems may produce collagen disease.

PERIARTERITIS NODOSA (POLYARTERITIS NODOSUM)

THIS is an obliterative inflammatory vascular disease involving small arteries and arterioles. It was described by Kussmaul and Maier in 1868. Its etiology is unknown, but in recent years some experimental work has pointed to possible hypersensitivity.

Gruber, in 1923, first suggested hypersensitivity as a cause. Rich and Gregory,³ in 1943, produced experimental serum sickness in rats and found periarteritis-like lesions in the viscera. These data are still questioned. Moschowitz sensitized animals to egg-white which,

TABLE 1. COMPARISON OF COLLAGEN AND ARTHRITIC DISEASES

Similarities	Dissimilarities (proportional to region involved)
1. Onset after traumatic stimuli such as infection, foreign protein, sun, physical agents, drugs, etc.	1. Rheumatoid arthritis . . . joints
2. Joint pains	2. Rheumatic fever . . . heart
3. Chronicity	3. Scleroderma . . . skin
4. Globulin changes	4. Lupus . . . serous surfaces
5. Vascular changes, purpura, serositis, and renal involvement	5. Periarteritis . . . vascular tree
6. Cardiac lesions; occur in rheumatoid arthritis, rheumatic fever, lupus, etc.	6. Dermatomyositis . . . muscles
7. Nodule formation in:	7. Calcinosis . . . diffuse tissue involvement.
a. Rheumatoid arthritis; subcutaneous, muscular and neuritic	
b. Rheumatic fever	
c. Dermatomyositis	
d. Lupus	
e. Scleroderma	

when re-injected, produced glomerulonephritic and periarteritic lesions.

Selye injected DOCA in rats and produced an arthritis-like rheumatic fever and polyarteritis. In humans the disease frequently has its onset after drugs such as foreign sera, sulfonamides, iodides, Dilantin,[®] or diseases as trichinosis, glandular tuberculosis, etc. Thus, a hypersensitivity reaction may elicit the disease manifestations. There is a high incidence of asthma, hives, hayfever, etc., in the history of these patients. Eosinophilia often occurs during the acute phase of the disease.

At present the hypersensitivity theory is in vogue but not yet proved.

PATHOLOGIC changes are in proportion to the vessels involved and thus very variable. Certain organs are involved more frequently than others, in this order: kidney (80%), heart (60%), liver (47%), spleen, lungs, mesentery, nerves, skin and brain.

The lesions are patchy and consist of four stages:

- 1.) Degeneration—Hyaline degeneration of the media with serous exudate, fibrin and coagulation necrosis.
- 2.) Inflammation — The vessel walls are infiltrated with neutrophils, eosinophiles, lymphocytes, and plasma cells.
- 3.) Granulation—Fibroblastic proliferation and occlusion of the vessel lumen.
- 4.) Healing—Production of scar tissue and obliteration of the vascular lumen.

All stages proceed simultaneously and progress may be rapid or slow. The results are thromboses, ischemia, infarction and fibrosis in the organ involved. The vessels exhibit aneurysmal dilatation and nodules along the arteries, but the veins are rarely affected. Other systems are involved but this is chiefly an arterial disease.

Clinically the syndrome resembles a sepsis or toxemia. There is fever, weight loss, anorexia, cachexia and emaciation. Symptoms depend on the organs concerned and the rate of the disease process.

TABLE 2. ORGAN SYSTEMS INVOLVED IN POLYARTERITIS

(Major manifestations in *italics*)

1. Kidneys — resembles acute glomerulonephritis with *albumen*, hematuria, etc.
2. Vascular—ruptured aneurysms.
3. Cardiac — coronary insufficiency, *hypertension*, angina; electrocardiographic changes.
4. Skin—nodules, purpura, petechiae.
5. Neurologic—neuritis, paralysis, sensory changes, cerebral involvement.
6. Muscles and joints.
7. Abdominal—thromboses; abdominal pain, nausea, vomiting, melena; jaundice; enlarged spleen.
8. Pulmonary—cough, pain, dyspnea, *wheezing*.
9. Lymph nodes—enlarged.
10. Laboratory—eosinophilia, hematuria, albuminuria, leucocytosis, hyperglycemia.

The prognosis is grave and fatal in 90 to 95 per cent of the cases. There are some spontaneous remissions, but the disease is worse when it involves the kidneys, lungs or other viscera. Occasionally resolution occurs when a non-vital organ is involved alone.

THERAPY is multiple and unsatisfactory, including ACTH and cortisone which may produce temporary relief. However, rapid healing due to drugs may lead to serious infarcts.

Joint and muscle symptoms are very common in this condition and their incidence has been reported as high as 70 per cent. This is due to the polymyositis and polyneuritis resulting from the basic pathology. The muscular and joint complaints vary from myalgias and arthralgias to acute and chronic polyarthritides.

Early joint symptoms include muscular aches and tenderness (30-35%). This is a result of ischemia with production of myositis and neuritis. The tender muscles are not necessarily nodular. This muscle pain and soreness may resemble trichiniasis. Other symptoms include burning sensations, paresthesias, and motor weakness, as well as early arthralgias. The symptoms increase with activity and are better with rest.

Seventy per cent of patients show polyarthritic changes; while 30 per cent have only a single joint involved. About 10 per cent exhibit joint swellings with synovial inflammations.

As this disease becomes established joint symptoms subside. In a rare patient migratory polyarthritides occurs.

Osteoporosis and local edema of the joint are common symptoms.

Joint manifestations may resemble gout, rheumatic fever, or rheumatoid arthritis.

Variations have been reported, including a child with symptoms resembling rheumatic fever who later developed periarteritis including flexion deformities. Hench reported a case with subcutaneous nodules.

Synovial biopsies show the same changes as in arteries elsewhere. However, there is a large blood supply and sufficient collateral vessels so that symptoms are less severe. This results in less true synovitis and more arthralgia. The synovitis is more histologic than clinical. Gross involvement is rare.

LUPUS ERYTHEMATOSIS DISSEMINATA

THIS is a disease of unknown etiology affecting the generalized connective tissue with changes in collagenous fibers resulting in organic symptoms. It affects all ages but is more common in women (80%) in their catamenial years.

The course is chronic with prolonged or short phases. The symptoms involve many systems.

Prominent generalized manifestations include fever, malaise, weight loss and anorexia. Eighty-five per cent of patients exhibit a typical butterfly rash which is made worse by exposure to sunlight. Polyserositis with pleural, pericardial, and synovial effusions is found in half the patients. Impairment of renal function, lymphadenopathy, splenomegaly, and purpura are often seen. Atypical verrucous endocarditis (Libman-Sack's disease) occurs. There may also be gastro-intestinal disturbances and signs of liver abnormality. Cerebral changes are occasionally noted.

The outstanding laboratory findings are increased serum globulin, leukopenia, albuminuria and hematuria, and electrocardiographic abnormalities.

The diagnostic test for this disease is the detection of the L-E cell in the blood. Biopsy of the skin or muscle may help establish the diagnosis.

The disease may show all or few manifesta-

tions and for this reason the diagnosis may be obscure and resemble any of other collagen diseases, such as lupus sine lupus.

PATHOLOGICALLY there are changes in collagen similar to those found in others of this group. There are "fibrinoid degenerations" with blood vessel changes. These involve any of the systems listed above. The glomeruli particularly exhibit so-called wire-loop changes (thick capillary basement membranes).

The prognosis is grave and the disease is fatal in about five years. Cortisone or ACTH may halt the progress and cause temporary remission. However, this problem is still unsolved.

The etiology is unknown and no definite allergic relationship has been established.

Eighty-five per cent of lupus patients show joint involvement.⁴ Fifty per cent have joint symptoms before the skin lesions arise. These early joint complaints may be vague and appear as long as five years before the disease itself becomes manifest.

When polyarthritis occurs as the only symptom the differentiation from rheumatoid arthritis becomes difficult, and the use of gold salts may cause an exacerbation of acute lupus erythematosus.

Joint complaints may occur as severe arthralgias which are out of proportion to objective findings and which may respond to salicylates.

Red, hot, swollen and tender joints, either multiple or single, migrating or localized, often herald an acute flare-up. The large and small joints of the extremities are usually involved, but rarely the spine. Exacerbations and remissions are common.

UNLIKE rheumatoid arthritis the joints in lupus do not become deformed and ankylosed. However, muscular atrophy and contractures are seen commonly.

Vasoconstrictive phenomena sometimes accompany the joint changes. Rarely, x-rays of the joints resemble rheumatoid arthritis.

In lupus the muscles may be tender, sore, weak or atrophic.

The important point in differentiation is that in lupus there are no true joint lesions in contrast to the findings in rheumatoid arthritis.

The disease may resemble fibrositis, rheumatic fever or rheumatoid arthritis.

Lowman studied the pathologic changes in twenty-five cases. He demonstrated muscle degeneration with vascular changes (edema, inflammatory reaction, sclerosis). He also found nerve changes. Synovial alterations were limited to the underlying vessels.

SCLERODERMA

THIS is a rare disease of unknown etiology involving the connective tissue of the skin or visceral organs by a process of proliferation and sclerosis of the collagen. Females are involved in a two to one ratio and the prognosis is grave. The course varies from acute to chronic.

The most common sites of involvement are the hands, followed by the arms, face, mouth, and chin. The legs and thighs are more frequently involved than the feet. Any part of the gastro-intestinal tract from the tongue to the anus may be diseased. There is also pigmentation of the skin.

Clinically, Raynaud's phenomenon may be present for years before the true disease is manifest; also prodromal paresthesias and arthralgias are common. Scleroderma starts as a circumscribed or diffuse induration of the skin with atrophy superficially. At first the skin becomes hard and immobile; later it is thin and atrophic like parchment. Finally, there is stiffness, deformity and shrinkage of periarticular tissues as in rheumatoid arthritis. The viscera are similarly involved. Calcinosis is noted commonly in the tips of the fingers, arms and elbows, and there is absorption of the distal phalanges. Constitutional symptoms (fever, tachycardia, and weight loss) are rare.

Pathologic changes include edema, proliferation of connective tissue (organ or skin), sclerosis of collagen bundles and atrophy of the organ. The muscles show increased connective tissue, arterial obliteration, prolifera-

tion of the media and round cell infiltration. Muscles are secondarily involved as is bony disorganization.

JOINT involvement is absent. The chief joint changes are periarticular due to contractures and shrinking of skin. Thus it resembles rheumatoid arthritis. However, pain may be slight and there is no fusiform swelling; limitation of joint motion is from stiffness rather than pain. Cortisone softens the lesions and gives some increased motion with relief of the arthralgia.

Osler reported five of eight cases with arthritic changes. O'Leary⁵ reported twenty-four of forty-eight cases with joint symptoms as the earliest manifestation. They vary from pain, swelling and stiffness of the hands locally to generalized musculo-skeletal pain, with swelling and stiffness of the joints. The disease may simulate a diffuse arthritis.

The hands are initially involved in the majority of patients. In some, all joints of the extremities are involved with generalized symptoms. X-rays show sclerodactyly and periarticular changes.

In acrosclerosis (Raynaud's disease plus scleroderma) there is involvement of large and small joints with stiffness, aching and swelling of joints. This form eventually leads to clubbing, shortened joints, scars, stiffness and discoloration.

In all scleroderma cases joint symptoms are predominant for a long time prior to a definite diagnosis. This frequently is called rheumatoid arthritis until the true picture becomes apparent.

DERMATOMYOSITIS

THIS condition was first described in 1863 and is a nonsuppurative inflammatory disease involving the skeletal muscles, skin, and subcutaneous tissue (myositis and dermatitis). The etiology is unknown and it affects both sexes equally in the middle age group. The course is variable from a rapid downhill course to a chronic, atypical variety. About 25 per cent start after an acute infection. The onset is sudden (chills, fever, tender muscles) or in-

sidious with weakness, aches and eruption. The prognosis is grave and death (50 to 60%) is due to secondary complicating infection.

The chief clinical manifestations include a skin eruption which starts primarily on the eyelids and cheeks; also on the dorsum of the fingers, trunk, neck, etc. It is a violaceous, red erythema consisting of groups of small telangiectasias and edema of the skin and subcutaneous tissues. This becomes more firm, brawny and lardaceous with a bloated facial effect (like lupus since it covers the nose also). The skin and muscle locations are not correlated.

The pathology of dermatomyositis resembles other collagen diseases. There is an accelerated aging process and it is somewhat like calcinosis universalis or scleroderma. There are less vascular changes but many vessels show hyaline and collagen degeneration.

Although renal involvement is minimal, glomerular hyalinization and fibrosis may be found.

The skin may exhibit a "lupus butterfly" effect but there is no edema of the facial muscles.

CERTAIN evidence suggests an allergic background for this disorder. There may be early signs of erythema nodosum, erythema multiforme, urticaria, and eosinophilia.

The muscle pathology consists of a symmetrical nonsuppurative degeneration of striated muscle involving the orbit, pharynx, larynx, diaphragm and especially the limbs. There is tenderness, weakness and pain of these areas. Edema is marked and calcification occurs in the subcutaneous tissues. There may be only painless wasting but eventually there is atrophy and contractures of the muscles, claw-like hands and rigid spine.

There is no definite joint involvement since the disease is primarily a muscular one. Arthralgias are not uncommon. However, the muscular contractures limit and cause joint pain. Also edema may reach the joints and cause confusion with arthritis, but there is no real joint disease.

Many features of dermatomyositis resemble

those of arthritis, such as muscle pains, contractures (claw hand, rigid spine) and edema. To confuse the picture further, this disease occasionally occurs with rheumatoid arthritis and it responds to ACTH and cortisone. Deformities in dermatomyositis are due to contractures and the process ends as a muscular fibrosis. These contractures are chiefly in the elbows, knees, hips, and fingers.

RHEUMATOID ARTHRITIS

THE joint manifestations as a chronic polyarthritis with symmetrical involvement of small and large joints are well known. The difficulty arises in atypical forms of the disease where a diagnosis may be confusing and resemble the collagen diseases. However, more often the collagen diseases, particularly lupus, are diagnosed as rheumatoid arthritis. The danger comes from the use of gold or other therapy which is indicated in rheumatoid disease but contraindicated in lupus. A further difference is in the prognosis of the two diseases.

Certain characteristics of this disease suggest a relationship to the collagen diseases. These are changes in the serum globulin, allergy (possibly to streptococcus infections), subcutaneous nodules, and pathologic changes which involve widespread mesenchymal tissue as well as joints.

RHEUMATIC FEVER

JOINT changes in rheumatic fever are fairly typical. The usual migratory polyarthritis without residual joint findings is distinctive. Occasionally minimal or single joint changes are seen. The chief difficulty is in distinguishing other collagen diseases, such as periarteritis and lupus, which may mimic rheumatic fever.

A possible relationship to the collagen diseases has been suggested by the following: altered sensitivity as emphasized by atypical activity when exposed to an external stimulus such as hemolytic streptococcus; increased streptococcal hyaluronidase activity; relief by cortisone; occasional vascular lesions resembling

ling those of periarteritis nodosa; involvement of mesenchymal tissues; and skin nodules.

SERUM SICKNESS

THIS is an allergic response to serum or other allergen. The reaction of hypersensitivity occurs one to two weeks after the foreign injection and lasts approximately seven to ten days. The symptoms and signs include lymphadenopathy, itching, fever, edema, and purpura. Joint symptoms include severe pain, stiffness and effusions of medium and large size joints. These effusions resemble rheumatic fever. They clear in a short period of time although stiffness may last the longest. There are no permanent joint changes.

Pathologically this is a mesenchymal disease with involvement of the spleen, joints, increased globulin, capillary permeability. In the rare patient who dies both vascular and fibrous changes are found.

ERYTHEMA NODOSUM

THIS is a condition manifesting fever, sore throat, malaise, arthritis, and a typical rash. The rash exhibits transient nodules like hives. They are circular, red, raised, warm and tender. The condition recurs in attacks like rheumatic fever. There is a questionable association with tuberculosis, rheumatic fever, streptococcus infections, and drugs such as sulfonamides and iodides.

Arthritis is found in 80 per cent of the cases. In 20 per cent there is a history of mi-

gratory polyarthritis prior to the skin involvement.

The arthritis manifests itself by pains in joints including the ankles, knees, wrists, elbows and shoulders. The course is phasic and there may be pain, swelling and occasionally redness and fluid. The joint changes may last one to three days and the disease is self-limited in about one to five weeks. Occasionally the course is longer. About 10 per cent become chronic and have both chronic joint and skin manifestations.

X-rays are negative. The general picture resembles palindromic rheumatism or rheumatic fever. Possibly it is a disease of hypersensitivity but there is no definite proof.

SUMMARY

JOINT manifestations are common during the course of the collagen diseases, but do not form definite diagnostic groupings. However, the collagen diseases exhibit certain characteristic forms of joint symptoms. Differential diagnosis of the collagen group (lupus, scleroderma, dermatomyositis, and periarteritis) and the rheumatic group may be difficult. Atypical joint manifestations confuse the diagnosis.

The serious prognosis of some of the diseases in this group requires a thorough knowledge of all manifestations which may aid in the differential diagnosis. Joint changes in the so-called collagen group are more commonly para-rheumatic or neuromuscular than truly synovial. Lupus most closely resembles the rheumatic group in its joint manifestations.

32 Johnson Avenue

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ALFRED O. DAVIES, M.D.

Millville

WILLIAM H. GLASS, M.D.

East Orange

FERDINAND ROTH, M.D.

Livingston

Subtotal Congenital Atresia of the Duodenum*

Subtotal congenital atresia of the duodenum in an adult is unusual; such patients rarely survive beyond infancy. The tenth reported case successfully treated by surgery is described.

IN REVIEWING the literature, one might infer that atresia of the gastro-intestinal tract is a rare pathologic entity. In an exhaustive review, Evans¹ reported 1498 cases recorded to date. It is interesting that these lesions occur with decreasing incidence from the ileum proximally to the duodenum, where they are found least frequently. Evans stated that operative correction was successful in only 139 patients (10.8%) in his series.

The greatest number (86 or 62%) of those successfully treated were duodenal atresias (including the duodenojejunal flexure), despite the fact that the lesions occur in this segment most infrequently. This is probably due to earlier investigation, recognition, and operative correction of the defect. If surgery is not resorted to early, the "milieu intérieur" becomes so disturbed by persistent vomiting that the attendant fluid, electrolyte and nutritional imbalances result in a poor prognosis for survival, with or without surgery. Undoubtedly, many infants with stenoses have died with their underlying pathology unrecognized, but an in-

creasing awareness of this condition is resulting in an earlier diagnosis and surgical correction, particularly of those of the "complete" or "total" type. On reviewing the literature one realizes that little has been added to our diagnostic methods since Jacobi's work in 1861.

HOWEVER, a small percentage of patients with atresia of the bowel of the "incomplete" or "subtotal" variety (Evans' classification) have survived and reached adult life before coming to surgery, despite the fact that they almost universally have manifested obstructive symptoms in their earlier years. Those of the complete variety either die unrecognized or without treatment or are treated surgically, with varying results.

To date, only nine cases of subtotal congenital atresia of the duodenum (including the duodenojejunal flexure) have been recorded in which the patient survived until adult life and

* From the Department of Surgery, Orange Memorial Hospital, Orange, New Jersey.

the defect was successfully corrected surgically. However, we feel that many such cases may go undiagnosed because the deformity is not sufficiently investigated and demonstrated at the time of laparotomy for obstructive symptoms. We wish to present a patient who, we believe, is the tenth adult treated successfully for this lesion by surgery.

CASE REPORT

A 54-year old Negro male came to the accident room complaining of painful abdominal distention. Examination revealed a tall, poorly-nourished male with evidence of chronic malnutrition and dehydration and exhibiting marked loss of skin turgor. The most striking feature of the examination was a greatly distended abdomen, resulting principally from a hugely dilated stomach which extended slightly obliquely and downward across the abdomen to the pelvic brim. Gastric aspiration yielded 7000 cc. of dirty-brown fluid, the latter part of which appeared like dark brown sludge. This resulted in complete relief of pain and abdominal distention. The patient was admitted with a tentative diagnosis of a stenosing peptic ulcer, probably duodenal.

The patient presented a long and somewhat bizarre history of dyspepsia. He stated that he had no gastro-intestinal complaints (this was confirmed by older members of his family) until the age of 8 years, at which time he first began to experience intermittent and remittent spasms of abdominal pain, lasting one to ten hours, located in the midepigastrium and associated with marked weakness, faintness and diaphoresis. At first the ingestion of food (particularly fruits, nuts, carbonated beverages, leafy vegetables and fresh pork) would precipitate an attack. The pain and associated symptoms were relieved by standing on his head. The latter maneuver was often repeated in order to obtain relief and he credits his failure to vomit (despite frequent nausea) to this measure. The patient stated that as a boy it often took him several hours to walk into town because he had to stand on his head so many times in order to obtain relief of his pain. His appetite was huge (he weighed 210 pounds at 12 years of age), but the more he ate or drank the worse was the pain. After 12 years of age the pain occurred immediately *post cibum* and he obtained relief only by standing on his head. Ingestion of either fluids or food produced complaints. The patient was never able to hold a job because the bouts of pain incapacitated him.

He weighed 210 pounds until November 1951, at which time he began to vomit three to four times a day (approximately 2000 cc.) irrespective of whether or not he ate. He had no real nausea, although there was a frequent desire to vomit. Vomiting always completely relieved his pain.

The patient was examined and treated by many physicians during this 46-year period, and surgery

was repeatedly advised but refused. According to the patient, in 1937 he was fluoroscoped and told that he had a "closed esophagus" and needed an operation. In 1942 a gastro-intestinal x-ray series showed a "narrow esophagus" and in 1944 repeat x-rays showed "narrowing of the gullet"; at this time he also had a gastric analysis performed and gastrectomy was advised. In 1945 an esophageal bougie with an inflatable cuff was passed; its inflation produced profuse hemorrhage. The latter again occurred when he was esophagoscoped in 1947 and at that time he was told that he had a "closed esophagus with fibrous tissue."

In November, 1951, he first began to vomit in addition to his pain, and he induced vomiting five to eight times daily until six weeks prior to admission, when he found that he could no longer vomit voluntarily. At this time the patient was given injections of mercurial diuretics because of abdominal distention thought to be ascites. However, distention persisted and approximately 8500 cc. of fluid were aspirated from his stomach two weeks before admission.

The patient was one of 23 siblings and there were no digestive complaints or known congenital anomalies in any of the other children.

The patient weighed only 139 pounds on admission to this hospital on November 5, 1952. A gastro-intestinal series on November 11, 1952, revealed 95 per cent gastric retention after 24 hours and the duodenum was not visualized during fluoroscopy or on the x-ray films. The radiologic impression was "pyloric or duodenal stenosis." On November 20, 1952, esophagoscopy revealed marked injection and congestion of the esophageal mucosa, with narrowing of the distal end of the esophagus. This was believed to represent peptic esophagitis.

The hemoconcentration present on admission is evident from Table 1 since his first red blood count and that after receiving three transfusions (1500 cc.) of whole blood were the same, namely, 4.3 million. A Mosenthal test revealed a poor renal concentrating capacity (1.002-1.015) pre-operatively. 2500 cc. of blood were given prior to surgery, satisfying the deficit indicated by pre-operative blood volume studies.

On November 27, 1952, following gastric lavage with saline twice daily and parenteral alimentation attempting to correct fluid and electrolyte imbalances, celiotomy was performed.

The stomach was enlarged and somewhat dilated, filling most of the left hypochondrium and epigastrium. There were several thin, veil-like bands extending from the junction of the first and second portions of the duodenum to the region of the gastric antrum. There was a small whitish area on the anterior aspect of the duodenum just distal to the pylorus which on first inspection was thought to represent slight scarring. However, subsequent sections of this area revealed no evidence of old or recent ulceration.

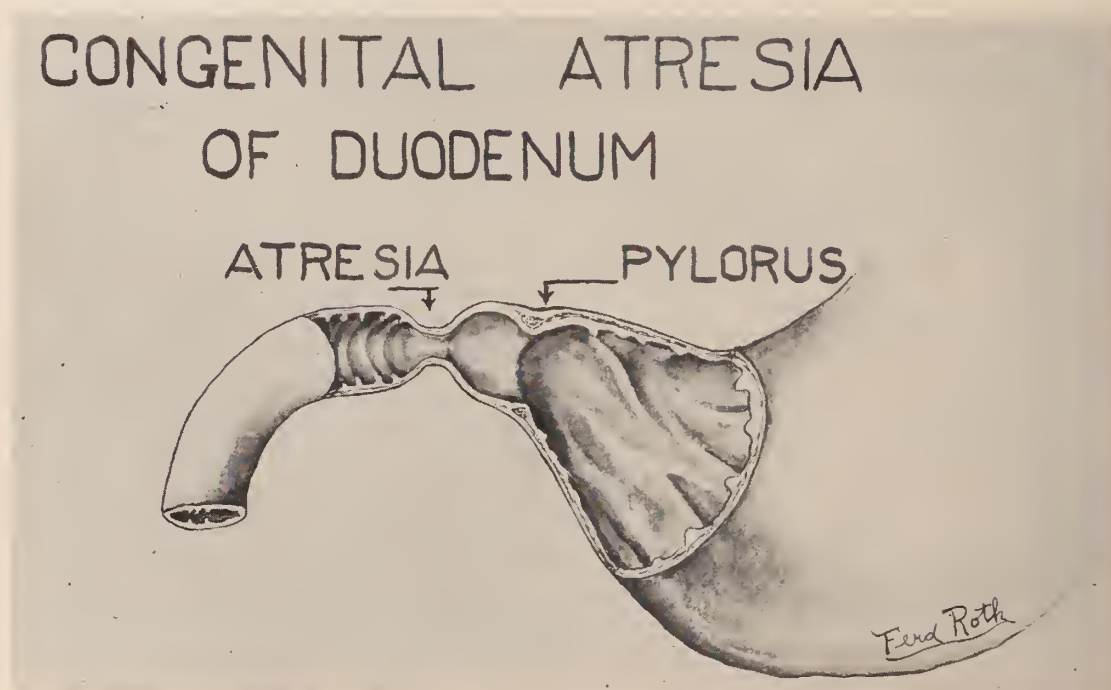
The duodenum was easily mobilized and was not fixed by scar tissue. Approximately two centimeters distal to the pylorus the caliber of the duodenum narrowed abruptly (see Figure 1.) from normal size

TABLE 1. LABORATORY DATA

Date	Na*	K*	Cl*	Hemato- crit	RBC	Hemo- globin	Blood Given	CO ₂ *	Urea N- NPN	tro- gen	Serum Protein	Ceph. Floc.
Nov. 10, 1952	112	3.9	98.3		4.36	13.7			37	14	Alb. 3.8	Neg.
Nov. 12							500 cc				Glob. 2.5	One plus
Nov. 15	127	6.2	102.6	42%	4.61	14.8		22.6				
Nov. 18							500 cc					
Nov. 19	140	3.1	98.3				500 cc					
Nov. 21					4.31	13.6						
Nov. 22							500 cc					
Nov. 24		3.3										
Nov. 25				46%	5.26	16.2						
Nov. 26							500 cc					

* Expressed in milli-equivalents

FIGURE 1.



to less than that of a lead pencil for a distance of 2.5 centimeters. A number 14 catheter could just be passed through its lumen. Bile was returned and there was no evidence of congenital diaphragm or other obstruction.

A high (approximately 80%) subtotal gastric resection of the Hofmeister antecolic, isoperistaltic variety was performed. The patient had an entirely uneventful postoperative course and was discharged on the tenth postoperative day "eating without pain for the first time he could remember and having normal daily bowel movements for the first time in his life."

COMMENT

THIS case represents the first reported case of congenital subtotal duodenal atresia in an

adult successfully treated by subtotal gastrectomy. We regard this as the treatment of choice for such a condition in an adult where obstructive symptoms exist with hyperacidity. We believe that the mechanism of obstruction in this case was intermittent angulation of the stomach, distended with fluid or food, at its junction with the atretic first portion of duodenum, with obstruction of the lumen of the constricted duodenum and superimposed inflammation and edema. This accounts for the relief which the patient usually obtained from standing on his head, thus straightening out the angulation in the pyloroduodenal region and permitting the

egress of fluid and food from the stomach through the constricted portion of duodenum.

The anatomic types of obstruction previously reported include those of the subtotal septal,^{3,4,5} annular and tubular varieties. In the adult, operative procedures have included duodenojejunostomy^{5,8,9} and gastrojejunostomy.^{4,6,7} Duodenal obstruction of the membranous (diaphragm) type has been successfully treated by dilation and incision of the diaphragm together with transverse suture of the longitudinal incision made in the intestine, and also by excision of the septum and duodenojejunostomy.

PYLOROPLASTY has been attempted but is a most unsatisfactory procedure since one is not dealing with normal tissue in the atretic area. It is undesirable to attempt an anastomosis of this thinned-out duodenum, the tissue pattern of which, according to Evans,² is distorted rather than arranged in orderly layers. In addition, if gastric acidity is high (and it frequently is, as illustrated by the peptic esophagitis in our patient, due to reflux of gastric acid), the incidence of peptic ulceration and its attendant complications will be high at the anastomotic ring if this is the only procedure.¹³ Gastro-enterostomy is unsatisfactory for the same reason. In the past, when gastrectomy was an extremely formidable, if not prohibitive, procedure, these other measures repre-

sented life-saving expedients but are certainly not ideal with present-day surgery. When these patients are adequately prepared pre-operatively, the mortality and morbidity from subtotal gastrectomy should be no greater than when this operation is performed for other benign gastro-intestinal lesions.

In infants and children, Ladd and Gross^{11,12} prefer a short-circuiting anastomosis. Gastrojejunostomy has been advised for obstructing lesions above the papilla of Vater and duodenojejunostomy in all other types of duodenal obstruction. Enterostomy has been condemned as uniformly fatal by Ladd and Gross, although Lee¹⁴ has performed jejunostomy with success in two newborn infants.

SUMMARY

1. A case of duodenal obstruction in an adult, caused by congenital subtotal duodenal atresia of the tubular variety, and successfully treated surgically, is presented.

2. The authors feel that this lesion may be demonstrated more frequently in cases of duodenal obstruction if the pathology is well visualized and considered in the differential diagnosis.

3. Congenital subtotal duodenal atresia is discussed from the standpoint of diagnosis and treatment, with particular regard to the advisability of subtotal gastrectomy as the treatment of choice in the presence of hyperacidity.

416 North 4th Street (Dr. Davies)

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Gluten-Free Diet for Celiac Disease

Celiac disease, according to Sheldon,* can be handled more easily if the patient is maintained on a gluten-free diet. In a mild or early case this can be attained simply by avoiding wheat or rye protein.

In England the Energen Foods Company, Ltd. separates wheat flour into its protein and starch components. They are thus able to make available the whole wheat starch which can be made into bread, biscuits and cakes. Special recipes are required because in the absence of gluten a wheat starch loaf would crumble to pieces unless some substitute is found for the binding properties of gluten. Fat (margarine) and milk are used in its place.

If early symptoms of celiac disease are recognized and a strictly gluten-free diet prescribed, rapid improvement of the celiac child should follow and the downward trend prevented.

When celiac disease becomes severe, however, skillful nursing and feeding must be

added to the gluten-free diet. In the beginning the diet may have to be limited to such simple foods as skimmed protein milk, glucose and banana purée. If the stools are frequent and watery a pectin preparation must be added. In the most severe cases intravenous fluids may be required.

As the child improves, chicken, egg custard and biscuits made from soya flour are gradually added to the simple diet. Fruits and foods made with wheat starch come next and finally non-gluten flours such as rice, potato and maize. Adequate supplementary vitamins should also be given.

In England the outlook for celiac children has been greatly improved with the use of the gluten-free diet. Mortality from this disease has been reduced and the period of hospitalization diminished. The change from a wasting and miserable child to one who appears well nourished takes place in a few weeks. The dietetic requirements are simple and inexpensive and can be carried out easily in the child's home.

* Sheldon, W.: Celiac Disease. Post Graduate Medicine, January 1954.

NORMAN T. CRANE, M.D.

J. GEORGE DIAMOND, M.D.

HORST W. FEYERABEND, M.D.

ELLIS P. SINGER, M.D.

Plainfield

Waterhouse-Friderichsen Syndrome*

Acute meningococcemia requires treatment of overwhelming toxemia, infection and shock. The agents used in this disease are evaluated and a case reported.

ACUTE meningococcemia with shock (Waterhouse-Friderichsen syndrome) is characterized clinically by the sudden onset of headache, high fever, nausea, vomiting, and abdominal pain, and with the rapid appearance of petechial and purpuric spots on the skin and mucous membranes with or without meningitic signs. The patient rapidly deteriorates into shock with cyanosis, cold clammy skin, rapid thready pulse, unobtainable blood pressure, and progresses to coma and death within twenty-four to forty-eight hours.

Before the advent of sulfonamides, recovery from this syndrome was rare.¹ With these drugs, sporadic reports of recovery appeared in the literature.^{2,3} The combined use of penicillin and sulfonamides further increased survival.^{4,5,6} Nevertheless, many patients continued to die in shock despite these agents. Recently, vigorous adrenal replacement therapy, including parenteral administration of epinephrine has been advocated.^{7,8} More recently, the successful use of cortisone^{1,9} and hydrocortisone^{10,11} has been reported. However, treatment of the peripheral vascular collapse during the first twenty-four to forty-eight hours remains the major therapeutic problem. Based upon reports on the use of nor-epinephrine in the treatment of peripheral

vascular collapse from myocardial infarction, sepsis, post-operative shock, acute surgical emergencies and anesthetic complications,^{12,13} a case of Waterhouse-Friderichsen syndrome was successfully treated¹⁴ with nor-epinephrine for the first sixty hours, in addition to the other therapy already mentioned. The patient discussed below was given 1-nor-epinephrine when conventional therapy was failing. Transient improvement was noted but death ensued, autopsy revealing complete replacement of the adrenal glands by hemorrhage.

CASE REPORT

A five-year old white male was admitted to the hospital September 30, 1953, in a post-convulsive state. The patient was well until the night prior to admission when he complained of a sore throat. That night he was feverish, irritable, and vomited once. He awoke after a restless night and went into a generalized convulsion with cyanosis, twitching, and rolling of his eyes. This lasted five minutes with continuous twitching when seen by his physician, at which time the temperature was 105 degrees rectally. Physical examination revealed only a moderately severe pharyngitis. Penicillin, 400,000 units, and sodium phenobarbital, 100 mg., were administered and the patient sent to the hospital.

On admission, the patient was in a stuporous condition and incontinent. The temperature was 105.8 degrees by rectum, the pulse 196, respirations 34 and blood pressure 64/44.

* From the Department of Pediatrics, Muhlenberg Hospital, Plainfield, New Jersey.

The skin and mucuous membranes were gray and cyanotic. The face, chest and abdomen and to a lesser extent, the back and extremities, showed red and brown petechiae, some with necrotic centers. Examination showed subconjunctival hemorrhages and petechiae beginning to appear close to the limbus. The pupils reacted sluggishly. The throat was cyanotic and injected.

Enlarged submandibular and axillary nodes were palpated. The lungs showed diffuse rales throughout. The heart showed a tachycardia with bounding heart sounds. The tip of the liver and spleen were palpable. Neurologic examination showed some resistance on flexing the neck, hyper-reflexia throughout, with a positive Babinski sign on the right.

Laboratory studies on admission: white cell count 4,350 with 10 stabs, 35 segmented cells, 52 lymphocytes, 2 monocytes, and 1 normoblast. Urinalysis showed no sugar, 2 plus albumin, with numerous white blood cells in the sediment. Blood culture was subsequently reported as negative after 96 hours despite the addition of penicillinase.

Lumbar puncture revealed clear fluid with normal dynamics and chemistries. Three cells (lymphocytes) per cu. mm. were present. No organisms were found on smear and the culture was sterile after 96 hours. Smear from one of the skin lesions revealed many gram negative diplococci, singly and in pairs, with the morphologic characteristics of *Neisseria meningitidis*.

Vigorous therapy was instituted with continuous oxygen by tent, Combiotic,[®] cortisone, adrenal cor-

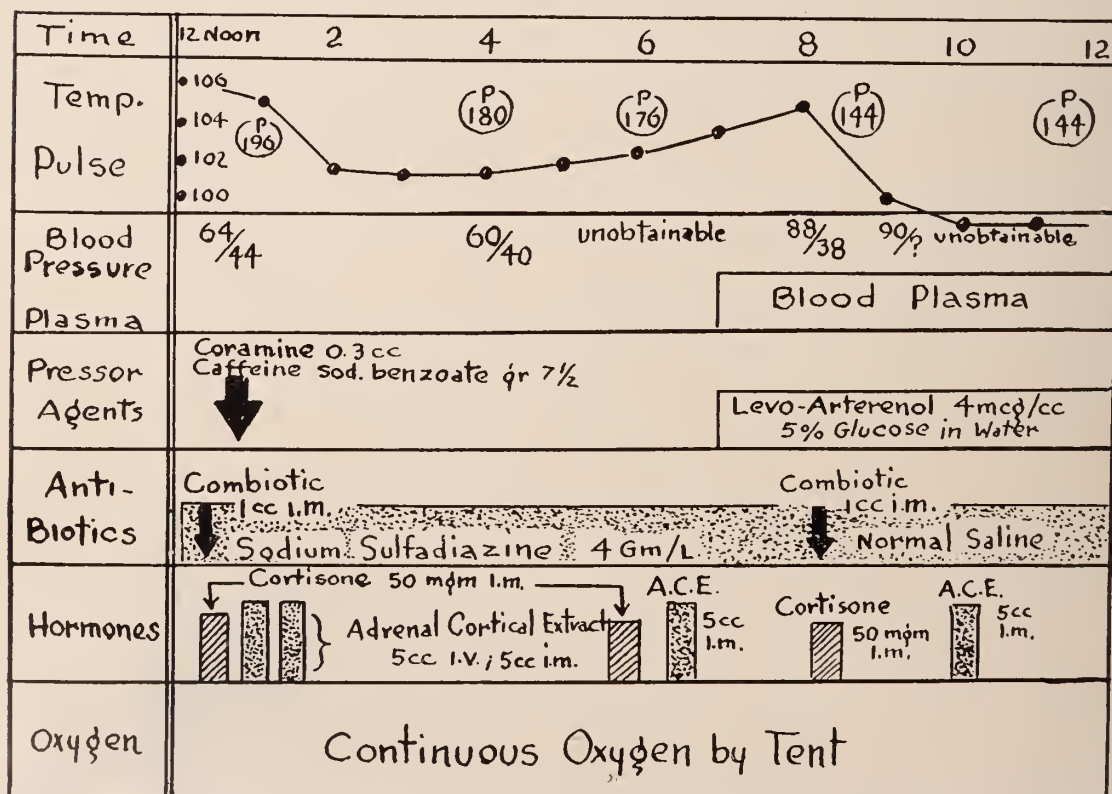
tical extract and an infusion containing 4 grams of sodium sulfadiazine per liter of normal saline. Within four hours, the patient improved with a drop in temperature to 101.2 degrees and a slowing of the pulse to 144 beats per minute.

However, he soon began to deteriorate with a rising temperature and pulse, and an unobtainable blood pressure. The circulatory collapse at this time was felt to be so severe that an infusion of levo-arterenol, 4 mcg. per cc. in 5 per cent glucose in water and an infusion of plasma were started with a return of the blood pressure to 88/38. Under continuous observation, this pressure was maintained for over an hour, but despite continued oxygen, sulfonamides and antibiotics, fluids, plasma, adrenal cortical extract, cortisone, and levo-arterenol, the patient died approximately thirteen hours after admission to the hospital. A summary of the treatment and course in the hospital is presented in the figure below.

Autopsy: The body was that of a well developed, well nourished young male with cyanosis of the ears and lips and a café-au-lait color to the skin. There were many petechiae and purpuric spots on the trunk and extremities and two on the conjunctivae. Some showed central necrosis. The brain showed edema with congested vessels and pinpoint petechial spots on the cortex. The lungs showed basal congestion. There were several fine subpleural petechiae. Others were seen in the mediastinal pleura posteriorly. The pericardial cavity was clear.

The heart was of average size, but the myocard-

FIGURE 1.



dium was soft and flabby with pallor of the muscle. Liver, spleen and pancreas were unremarkable. The most striking findings were in the adrenals. They were enlarged and almost completely destroyed by hemorrhage so that only a suggestion of cortex remained. The kidneys showed marked cortical swelling and were soft and flabby with vascular congestion.

Microscopically, the skin showed patchy hemorrhage into the dermis. Sections of brain showed no inflammatory changes. The lungs showed moderate congestion and edema with patchy atelectasis. There were focal collections of lymphocytes scattered throughout the lungs. Sections of liver showed blurring of cell outlines and periportal collections of lymphocytes. There were histiocytes in the sinusoids containing granules and resembling Kupfer cells. Sections of kidney showed congestion, with swelling of glomeruli and tubular epithelium with red blood cells in the tubules. The adrenals showed almost complete destruction of cortex and medulla by hemorrhage with only a few small areas of cortical cells remaining at the periphery.

The final diagnosis was purpura and petechial hemorrhages of conjunctivae and skin, toxic myocarditis and hepatitis, mild pulmonary edema and bilateral severe hemorrhage of the adrenal cortex and medulla.

DISCUSSION

THIS patient illustrated the classic picture of a severe Waterhouse-Friderichsen syndrome with death in less than 24 hours despite the liberal use of antibiotics, chemotherapy, fluids, plasma, oxygen, adrenal cortical replacement and a vasopressor agent. Although the overwhelming toxemia plays an important role in contributing to a fatal outcome in this disease, the peripheral vascular collapse is a primary problem. In the case under discussion, intramuscular penicillin in a dose of 400,000 units apparently so sterilized the blood stream that a blood culture was negative. However, it cannot be denied that the infectious element played a large part, for a positive smear of a purpuric lesion indicated that the organism had invaded the body tissues. The leucopenia of 4,350, with no shift to the right and only slight shift to the left, indicated a poor response to infection.

It is significant that Daniels' study⁵ of Army autopsy material showed that 50 per cent of 126 patients dying of fulminating meningococcemia with adrenal hemorrhage did not have meningitis. In fact, patients with meningitis have a better prognosis. If overwhelm-

ing infection were the main factor, one would expect a poorer prognosis in patients showing frank meningitis.

Acute adrenal insufficiency has been considered a significant factor in the syndrome. Daniels' study showed a roughly inverse correlation between the duration of life and the degree of adrenal hemorrhage. The case presented here, with almost complete adrenal hemorrhage, had a relatively short duration of life: sixteen hours after the onset of convulsions, and would confirm this concept.

HOWEVER, that adrenal insufficiency is not the primary etiologic factor is supported by the fact that adequate adrenocortical substitution therapy does not prevent death.¹ Our case is an example of this. Uhl's patient showed no evidence of adrenal insufficiency by studies of eosinophil counts and 17-ketosteroid excretion. Bjorklund⁸ treated a five-year old girl with this syndrome and determined 11-oxysteroid and 17-ketosteroid excretion before treatment and during the acute phase and found normal values.

Therefore, treatment of the peripheral vascular collapse seems to be the primary problem. Whether this collapse is due to the overwhelming toxemia is not known. Recent studies using hydrocortisone (compound F) may shed light on this phase of the disease. Shaw and his associates¹⁰ reported recovery of nine out of twelve cases using hydrocortisone plus the other measures already discussed. They postulate that adrenal steroids of the cortisone type act as non-specific antitoxins inhibiting the total inflammatory response, decreasing toxicity and therefore preventing shock. They feel hydrocortisone is more effective than cortisone: two of their three fatalities occurred in patients receiving cortisone and not hydrocortisone. They feel that hydrocortisone exerts a pharmacologic effect over and above its physiologic effect as adrenal replacement therapy. This viewpoint is supported by Bauman.¹¹

The use of 1-nor-epinephrine (levo-artenol) to combat the vascular collapse was successful in Uhl's case and tried in our patient. Although the outcome in the latter was even-

tually fatal, we were impressed by the temporary improvement effected by the drug. Bjorklund feels that the ultimate cause of peripheral vascular collapse is extensive capillary vascular damage with hyaline thrombosis and that the use of nor-epinephrine combats this.

Whether these newer forms of treatment can salvage more lives in this severe fulminating disease warrants further study in view of encouraging reports so far.

SUMMARY

A CLASSIC case of Waterhouse-Friderichsen syndrome with severe bilateral adrenal hemorrhage and fatal outcome within twenty-four hours of onset is presented. Therapy included continuous oxygen, chemotherapy and antibiotics, intravenous fluids, plasma, adrenal

replacement therapy, and a vasopressor agent: levo-arterenol. Despite these vigorous measures, death ensued after temporary improvement with levo-arterenol.

The mechanism of shock and death is discussed. The latest emphasis is on combatting the peripheral vascular collapse. 1-nor-epinephrine, used to combat the vascular collapse accompanying other medical and surgical conditions, has been reported successful in treating the shock accompanying the Waterhouse-Friderichsen syndrome. Our case showed transient improvement with this therapy. Indirect evidence indicates that hydrocortisone has a pharmacologic action in addition to the physiologic action of the cortisone type steroids and acts as a non-specific antitoxin against shock. The ultimate place of these newer preparations has to be determined after further study.

1177 Park Avenue (Dr. Singer)

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Sympathectomy in Vascular Disease of the Extremities[†]

Indications for anesthetic and surgical lumbar sympathectomy are described with stress placed on the need for individualization of treatment.

IT is well known that the autonomic nervous system controls the caliber of blood vessels, and in extremities this is mediated by the sympathetic chain. There are variable labile reactions to heat, cold, fear, excitement, and nervousness. The autonomic reactions to surgical shock are also well understood. However, the role of the sympathetic fibers in pain, acute injury, blood vessel occlusion and frost bite, as well as chronic degenerative vascular disease, has only recently been appreciated.

At first surgeons were hesitant to sympathectomize an extremity. They feared that the permanent loss of blood vessel control might be detrimental to the later well being of the limb in removing its reactions to changing environment. There was also the question of "paradoxical sympathectomy," where the extremity apparently receives less blood flow than before sympathectomy. Now it is evident that lumbar sympathectomy is not damaging and not detrimental.

TYPES OF SYMPATHECTOMY

THE term sympathectomy here refers to interruption of the action of the lumbar chain on the lower extremity.

There are four methods of inhibiting the action of the lumbar sympathetic outflow:

1.) *Medical*—by drugs which stimulate vasodilatation.

2.) *Surgical*. A. Transient—by the in-

jection of 25 to 30 cubic centimeters of 1% novocain directly around the lumbar sympathetic chain, either entirely at level L₂, or by distributing the solution through multiple punctures along the lumbar chain.

B. Prolonged—a block with some long-lasting local anesthetic which is slowly absorbed due to its vehicle. Another technic is to administer a slow drip of 1% novocain through a malleable needle left in situ, either over the lumbar chain or in the caudal canal.

C. Permanent Sympathectomy—the extirpation of the second and third lumbar ganglia with the intervening chain, removing all communicating rami in this area. L₁ is best avoided in order to not involve higher sympathetic impulses. L₄ is avoided, at least on one side, so that impotence will not supervene.

INDICATIONS

DISCUSSION here will be limited to the last three methods and the indications for each. Illustrative cases will follow.

Temporary block with 1% novocain is often used to determine if more lasting interruptions are indicated. This has been discarded in many places as it is felt it is inconclusive or at times misleading. For example, a post-injection reaction of warm, dry foot in arterial insufficiency

* Chief of Vascular Clinic, Presbyterian Hospital, Newark.

† Presented before the Cardiovascular Disease Section at the Annual Meeting of The Medical Society of New Jersey, May 18, 1953.

may not mean that a lumbar sympathectomy will be helpful. The converse is also true. Some clinics however still retain the novocain block as a preliminary test.

One per cent novocain injection is also used to relieve the reflex spasm accompanying both acute and deep phlebitis. Usually, the more recent the onset the more effective it will be. However, results have been obtained in chronic phlebitis of from eight to ten years' duration, the longest being thirteen years after the first pain and swelling. Although the blocking effect theoretically remains only as long as the action of the novocain, nevertheless, it seems to relieve peripheral spasm much longer. The foot will remain warm many hours after the novocain has worn off. In chronic deep phlebitis the edema, which may be of several years' duration, is reduced. Sometimes the block needs to be repeated after several weeks, but usually after a second one the reflex arc is broken. Occasionally permanent sympathectomy is necessary.

In vasospastic disorders following injury or inflammation temporary block is often beneficial. It has also been used in acute vascular accidents, in thrombosis and embolism and in crushing injuries, but in these instances some longer lasting interruption is usually indicated.

ONCE the simplicity of prolonged block is appreciated, this modification gains in popularity. It is quite simple to use a Lemmon type soft needle to bathe the area, and it is also very comfortable for the patient. The chief indication is in acute injuries of the extremity, thrombosis or embolism, or in arterial injury, with its concomitant mass action vascular spasm of the extremity. In the crush syndrome and in blood vessel injury reflex spasm usually subsides within a period of days and therefore permanent interruption is not necessary. In arterial thrombosis permanent sympathectomy may be indicated due to continuing stimuli.

Prolonged anesthetic action on the sympathetic chain also may be valuable in recurrent vasospasm from long-standing deep phlebitis. In several cases of post-phlebitic edema, present for many years, good results have been obtained.

Surgical removal of the sympathetic chain is performed by resecting all connecting fibers and lumbar ganglia 2 and 3.

During surgery and for six to eight hours thereafter the patient must be watched carefully for a sudden blood pressure fall, the reflex primary shock occasionally seen accompanying autonomic nerve system surgery. Nor-epinephrine by slow intravenous drip is used in these instances. Other than this complication, most patients tolerate these procedures well. Extirpation produces very little surgical morbidity. Alcohol block has been abandoned due to an occasional severe neuritis.

Table 1 contains a list of pathologic conditions of the extremities helped by one of these three types of sympathectomy. It is important to choose the most indicated method. All three may be used at different times in a single case.

TABLE 1.
INDICATIONS FOR SYMPATHECTOMY

- I. Occlusive changes
 1. Degenerative
 - A. Arterial insufficiency
 1. Acute
 - a. Embolism
 - b. Thrombosis
 2. Chronic
 - a. Arteriosclerosis
 1. Diabetic—medial sclerosis
 2. Atheromatous — intimal sclerosis
 - B. Venous
 1. Thrombosis
 - II. Inflammatory
 1. Arterial and venous insufficiency
 - A. Buerger's Disease
(Thromboangiitis obliterans)
 2. Venous
 - A. Phlebitis
 - a. Deep
 - b. Superficial
 - III. Vasospastic changes
 1. Chronic
 - A. Raynaud's Disease
 2. Acute
 - A. Causalgia
 - B. Shoulder - hand syndrome
 - IV: Injuries due to cold
 1. Frostbite
 2. Freezing with loss of part
 - V. Vascular accidents
 1. Arterial injury
 2. Crush syndrome

The following cases illustrate the application of these technics and principles.

CASE REPORTS

No. 1. D. G., age 48, a storekeeper, developed a deep phlebitis in his left leg in January 1953. He was hospitalized and treated for two weeks with elevation and heat of the affected limb. He had a history of pain and swelling of the leg in November 1952, with a possible embolus in December 1952.

A temporary lumbar sympathetic block was performed, following which he had less pain and edema within twenty-four hours. He was advised to wear an Ace® bandage. One week later he had no swelling of the leg or ankle, the foot was warmer, and he could walk without a limp.

No. 2. D. S., age 42, a housewife, had infantile paralysis thirty-four years ago with residual weakness of the left leg and almost complete paralysis of the right leg. For the past eight to ten years she had swelling of both legs with tender spots on both lower legs. An ulcer on the outer surface of the right ankle failed to heal for six months. She was advised to lose weight, was given medical antispasmodics and alcohol. She experienced symptomatic relief in the next eleven months, but the ulcer would not heal completely and the legs continued to swell.

A right lumbar sympathectomy was performed in March 1953. At present the ulcer is healed, the swelling is less and the right leg is warm and feels much more "lifelike" than before. The patient is contemplating a sympathectomy on the other side to increase the circulation in the left leg.

No. 3. J. T., age 74, an engraver, had sudden paleness and coldness of the left leg without a history of injury or previous illness. He noticed a bluish discoloration of the left foot.

Examination was negative except for diffuse generalized arteriosclerosis. Oscillometric readings were diminished in the right foot and completely absent in the left leg below the knee. The diagnosis was thrombosis of the left popliteal artery. An emergency lumbar sympathectomy was performed followed by the return of warmth and color to the left lower extremity, the skin temperature coming to within two degrees of the right leg. He was advised to use antispasmodics and to stop smoking. He has been followed for the past five years and is still at work without disability.

No. 4. J. W., age 65, a plumber with auricular fibrillation, developed a saddle embolus which occluded both common iliac arteries. A transperitoneal removal of the embolus was done with a bilateral lumbar sympathectomy at the time of the embolectomy. There was no loss of limb.

No. 5. M. V., age 76, a housewife, who was a known fibrillator receiving digitalis, localized an embolus in the right common femoral artery. An embolectomy was performed within four hours. The operation was followed by repeated novocain lumbar sympathetic blocks. Later a polyethylene tube was placed in the caudal canal and an extradural block continued for three days. The patient was able to walk on leaving the hospital. She had no amputation, but some edema of the leg, possibly due to deep phlebitis, has persisted.

Four months later, the patient returned stating

that the left leg had been swollen for several months. She had been receiving diuretic medication intramuscularly, but the left leg had remained edematous. A lumbar sympathetic block was performed on this side and she was advised to wear an elastic stocking. She has had some subsidence of the edema, but it is not complete.

No. 6. H. R., age 47, a carpenter, complained of cramps in his legs after walking a short distance for the previous year. They were more severe in the left leg. On climbing ladders he experienced severe pain in the legs and a feeling of weakness upon reaching the top. He was a heavy smoker, consuming two packs daily.

He was found to have coldness of both legs with absent oscillometric readings. His blood pressure was 150/78. With a diagnosis of arteriosclerotic insufficiency, a left lumbar sympathectomy was performed. After three weeks he returned to work. He has stopped smoking. Three months later he returned for a right lumbar sympathectomy because of increasing pain in the right leg. He has now returned to work and is symptom-free.

No. 7. F. G., age 46, a salesman, has had Buerger's disease for the past three years with intermittent cramps on walking and migrating phlebitis at intervals. Examination shows arterial insufficiency, paleness on elevation, and rubor on lowering the extremities. A lumbar sympathectomy was performed on both sides. The patient has been relieved of some of his symptoms, although the pathology still exists.

No. 8. B. S., age 19, a college student, fell while skiing at college in February 1948. She complained of pain in her right ankle for several weeks. There was no swelling and an x-ray report was negative. She was thought to have a ligamentous injury of the right ankle. Although the ankle pain subsided, she noticed a tight constricting pain in the right foot and leg. This leg also felt colder than the left, the skin was very sensitive to touch, and the weight of the bedclothes became intolerable. She later developed pain in the right knee and hip with a limp. Finally, she walked on the right forefoot without touching her heel to the ground.

When first seen four months after the injury, she had spasm of the muscles of the lower back and hip on the right side. There was no limitation of joint motion but the muscles were spastic, especially about the ankle and knee. The right foot was cold to touch, and the skin temperature readings were four to five degrees lower than on the left. Oscillometric readings were also two units lower in the right leg. A diagnosis of post-traumatic sympathetic vasospasm in the right leg with resulting causalgia was made, followed by muscle spasm in the right leg and lower back.

After a lumbar sympathetic block with novocain the right leg became warmer, she could walk better and had less paresthesias. However, after a week the symptoms recurred. Another lumbar sympathetic block was performed with relief of symptoms. It was noted that only one to two degrees of difference then existed in the extremi-

ties. She was advised to take warm baths. Antispasmodics and sedation were also prescribed. After a few weeks this treatment resulted in complete relief of symptoms with oscillometric and skin temperature readings the same in both legs.

No. 9. C. L., age 80, a housewife, experienced pain in her left ankle and left calf on exertion, so severe she could walk only ten feet. She had recently developed pain up the back of the left leg over the course of the sciatic nerve. She was found to have free motion of all the joints of the left leg. X-rays showed marked calcification of the blood vessels in both legs. On palpation the peripheral blood vessel pulsations in both legs were diminished or absent. Oscillometric readings showed 2 units in the right calf, 0.5 unit in the left calf. The skin temperature reading of the left foot was two degrees lower than the right. The blood pressure was 218/140. Her diagnosis was bilateral chronic vascular disease, arteriosclerotic and hypertensive in origin. She was thought to have superimposed arterial vasospasm in the left leg following the left knee injury.

A left lumbar sympathetic block was performed with novocain and was supplemented by antispasmodics, warm baths, and oral alcohol. She experienced less pain on walking following these measures and the left foot became warmer. Intravenous novocain was also helpful.

No. 10. S. K., age 38, an itinerant, was found on a park bench after a two-day cold spell. He was brought to the Newark City Hospital where both his feet and hands were found to be frostbitten. His feet had blebs, were bluish in color, swollen, and there was evidence of beginning gangrene of two toes of the right foot.

A lumbar sympathetic block with 1% novocain was performed bilaterally on admission. Following supportive therapy a right lumbar sympathectomy was performed. His foot became warmer and of better color. Only a partial amputation of the two gangrenous toes was required.

DISCUSSION

THE reported cases were chosen to show examples of treatment in the various categories of Table 1. With as wide a range as is included in this table, it is evident that similar technics cannot be used. The treatment must be individualized for each patient. It should be stressed that there is no rule of thumb which will determine the type and extent of treatment to be used.

SUMMARY

SEVERAL methods of producing interruptions in the sympathetic outflow to the lower extremities have been discussed.

The disease complexes which may be helped by these procedures are listed, with illustrative cases.

The handling of these cases often crosses specialty lines and the knowledge of several specialties should be correlated to gain the optimum result.

161 Roseville Avenue

Combined Nephrography

A new method for visualizing the kidneys by x-ray has been described by Herzan.*

Following a routine unilateral retrograde pyelogram, using the largest possible catheter, the catheter is left in place and its free end clamped to prevent escape of the contrast medium. After x-rays are taken, 30 cc. of Diodrast® are given intravenously. Films are taken at 15, 25 and 35 minute intervals, until saturation of the kidney tissue is obtained. One nephrogram is done at a time, leaving the other kidney functioning.

By this method it is possible to demonstrate

the excretory portion of the kidney, thus producing more marked contrast between the kidney parenchyma and pelvis.

The contrast medium saturation of the kidney remains constant until the retrograde medium is released, thus as many films as desired can be taken at one sitting, including laminagrams.

No side effects have been noted and there is no pain associated with this method.

* Herzan, F. A.: Artificial Nephrography by Combined Retrograde and Intravenous Urograms. *Am. J. Roentgenol.* 71:228, February 1954.

DANIEL BERGSMAN, M.D.[†]
Trenton

Diabetes, a Public Health Problem*

Detecting diabetes early by adequate screening procedures inaugurates a new role for public health agencies.

IT HAS been estimated that there are 2,230,000 persons in the United States with diabetes and that only half of them have been diagnosed and are under appropriate treatment.

The role of the public health agency in diabetes control is to help locate these unknown cases and refer them to practicing physicians for appropriate care. This endeavor is not essentially different from that in tuberculosis control. The public health agency, through expensive case-finding equipment and staff, seeks to identify the person with suspected tuberculosis. Such persons are referred to physicians for additional study so that if the suspicion is medically confirmed the patient may receive proper treatment.

Case-finding of either diabetics or persons with tuberculosis is a prohibitively expensive process unless it is done on such a large scale that the unit cost is reduced to a minimum. This is obviously impractical for the average physician. It becomes an area in which the public health agency supplements the efforts of the practitioner. If proper procedures are used on large numbers of persons, even when those persons are presumably well, there will be found a number of reactors. The reaction is not a diagnosis. It is not the function of the public health agency to diagnose. The reaction or suspicion is merely a lead which enables us to refer

the individual in question to a physician earlier than otherwise. The private practitioner makes the diagnosis, and determines the course of treatment.

In the case of a communicable disease such as tuberculosis, case finding benefits not only the individual but also other members of the community because the disease is contagious.

BECAUSE untreated diabetes can result in damage to the blood vessels of the diabetic, it is important to him that his unknown ailment be detected. It is in keeping with our concept of constructive health, to help every individual achieve his best possible health.

Scientifically, we cannot prevent diabetes. It is the product, at least in part, of malfunction of the pancreas. Through proper diet and other measures, the individual who is disposed to diabetes perhaps may keep his pancreas functioning effectively longer than it otherwise would. There is little else we can do now to assure that the condition will not affect him sufficiently to require other treatment in the future.

Weight control is essential, not only in deferring the onset of diabetic manifestations, but in deferring the onset of other degenerative diseases. This helps to explain the increased

* Presented at the Symposium on Diabetes, Academy of Medicine of New Jersey, Newark, on October 21, 1953.

[†]State Commissioner of Health.

emphasis that is now being given to nutrition in public education.

We in public health who seek better health for all our people are grateful that you are taking the leadership in sponsoring efforts to detect illnesses among our population. This indicates that medical practitioners are not waiting for the sick person to come. You are showing that you have a sense of community responsibility which impels you to identify the sick person before his symptoms are so overt as to drive him to you. By getting him earlier, you

can treat him more effectively. You are thus advancing the cause of health among all people.

This effort is also an example of sound public relations. In the long run, an organization is judged not by what it says about itself but by what it does. In organizing to search for unknown diabetics, you are proving that you are your brother's keeper, that you are interested in lifting the level of health in your respective communities. In your endeavor, we wish you Godspeed. We in public health will assist you to the best of our ability.

Delayed Ligation of the Umbilical Cord

The value of delayed ligation of the umbilical cord following delivery has been described in the literature. Few articles, however, have stressed the importance of gravity in the transfer of blood from the placenta to the infant.

Duckman,* *et al.*, have recently studied ninety-four infants in regard to the effect of gravity in this respect. The infants were divided into three groups. The first consisted of twenty-three infants weighed on a scale placed six inches above the level of the mother while still attached by the cord to the placenta in utero. The second group, twenty-four infants, were weighed with the scale at the mother's level. The third group, forty-seven infants, were weighed six, twelve or more inches below the level of the mother. In all cases the infants were still attached to the placenta.

The results showed that while the umbilical cord is pulsating vigorously blood will flow from the placenta to the infant in varying amounts, favoring the one who is held below the mother's level. When the cord stops pulsating the transfer of blood from the placental vessels and cord to the infant is almost entirely dependent upon gravity. Holding the infant well below the mother's level for three minutes following delivery will add from fifty to seventy-five per cent of the available blood in the placental vessels and cord to the infant's

blood volume. With the cord pulsating well a contraction of the uterus around the separated placenta will frequently transfer much of the available blood to the infant.

Any trauma to the cord will hinder the flow of blood. Gently stripping the cord tends to overcome any temporary obstruction which is probably due to vascular spasm.

Holding the infant above the mother's level after delivery by Caesarean section may result in blood loss toward the placenta if the cord is not pulsating vigorously. This practice should be avoided.

There is no increase of jaundice of the infant due to delayed ligation. Infants, moreover, showed fewer complications and appeared more active and in better general health than those where severance of the umbilical cord was not delayed. Infants delivered with delayed ligation acquired fifty or more grams of blood and their hemoglobins were, on the average, 3.4 grams more than the controls. Their red cell counts were five hundred thousand per cubic millimeter better.

The authors recommend that the ligation of the cord be delayed for from three to five minutes. The infant should be held well below the level of the mother. If the placenta separates quickly it should be held up for from one to two minutes, especially after the cord stops pulsating and collapses. In this way the infant can be assured of at least two-thirds of the available blood in the placenta and its vessels.

* Duckman, S., *et al.*: Gravity and Delayed Ligation of the Umbilical Cord. *Am. J. Obst. and Gynec.*, December 1953.

H. S. IVORY, M.D.

Point Pleasant Beach

Clinical Use of TACE*

Experiences with chlorotrianisene, a new oral estrogen, are described, with a discussion of its pharmacology.

CHLOROTRIANISENE is a new compound with estrogenic activity.¹

Laboratory studies have demonstrated that chlorotrianisene, like hexestrol and other estrogens, causes estrogenic changes in the mammary gland, uterus and vagina, sensitizes the uterus to progesterone, does not alter thyroid abnormalities from thiourea administration and inhibits the gonadotropic hormone production by the pituitary.²

In experimental animals, chlorotrianisene differs from the older natural and synthetic estrogens in the following respects:

(1) It does not produce the pituitary enlargement characteristically seen with other estrogens.^{2,5}

(2) Unlike other estrogens, it does not cause degranulation of the beta basophiles and acidophiles of the hypophysis (although it resembles the older compounds in that it does produce an absence of delta cells.⁵)

(3) Chlorotrianisene produces little or no adrenal enlargement in rats.^{2,3,4}

(4) Chlorotrianisene is not inactivated by liver homogenates as are other estrogens.³

(5) Upon prolonged administration of a relatively high dosage, it accumulates and is stored in adipose tissue.⁶

Many believe that excessive adrenal activity is a major factor in the progression of prostatic carcinoma⁷—adrenal hyperplasia has been found at autopsy in persons who have died

from this condition. In experimental animals, chlorotrianisene produces little or no adrenal hyperplasia, which makes chlorotrianisene unique among estrogens.

THEREFORE, early interest in the clinical application of chlorotrianisene centered around its use in the palliative treatment of prostatic cancer. There are now 307 reported cases of prostatic cancer treated with chlorotrianisene, in some cases for over three years.⁸⁻¹³ The therapeutic response was generally favorable and the drug well tolerated, even in doses as high as 180 milligrams per day by mouth.¹²

There are several reasons for the clinical use of chlorotrianisene in estrogen deficiency states in the female:

(1) It is generally agreed that a decrease in blood estrogen levels occurs during the menopause. Whether the characteristic symptoms of the climacteric are due to diminished quantities of estrogen or to the upset of the delicate hormonal balance which results therefrom still remains an unsettled issue. More credence is being placed in the latter theory. In either case, an estrogen which restores normal values and produces clinical improvement without adverse physiologic or structural effects would be a notable advance.

(2) Continued daily doses of estrogen produce an elevation in blood levels, but these show a marked variation from day to day, as evidenced by peaks

* TACE is the trade-mark of The Wm. S. Merrell Company, Cincinnati, for its brand of chlorotrianisene (tri-p-arylchloroethylene).

† Medical Director, Jersey Shore General Hospital, Inc.

and valleys in blood estrogen curves. Chlorotrianisene, when taken in adequate dosage, is stored in the fat. From here it is released gradually and uniformly as long as it is administered, and in progressively smaller quantities when therapy is discontinued. With chlorotrianisene, therefore, maximum uniform estrogenic effect is available when needed in the early stages of treatment and later, the release of slowly diminishing amounts over a protracted period of time enables the patient to adjust more serenely to her normal postmature state.¹⁴ For the same reason, withdrawal bleeding should be much less frequent.¹⁵

PRELIMINARY RESULTS

The Menopause Syndrome

TWENTY menopausal patients, varying in age from 40 to 60, have been treated with chlorotrianisene. In each case the dose was 24 mg. daily (two capsules) for a period of four months. At the end of that period the dose was reduced to 12 mg. daily and all patients are still receiving that amount.

In all patients the characteristic symptoms of the climacteric were ameliorated, as would have been expected from adequate dosage of any estrogen. However, the feeling of well-being, which is difficult to measure but of substantial clinical importance, was striking with chlorotrianisene therapy. Moreover, metrorrhagia and menorrhagia were minimized; the decrease in bleeding probably was a major factor in the good subjective response.

Postpartum Engorgement of the Breast

NINE patients were treated for postpartum engorgement of the breast. In these the dosage schedule was as follows:

First three days: 12 mg. four times daily.
Next two days: 12 mg. three times daily.
Last two days: 12 mg. twice daily.

In eight of these nine patients this schedule was adequate; there was no painful engorgement of the breasts. In the remaining patient, symptoms recurred on the 12th day. Chlorotrianisene, 12 milligrams three times daily, was

given for two days and the symptoms were relieved.

Postpartum Atonia of the Breast

IN two patients there was loss of shape and tone of the breast following parturition. Chlorotrianisene was administered orally in daily doses of 12 milligrams for 30 days. Improvement began on the eighth day in one case and on the tenth in the other. In both there was a recurrence after discontinuation of medication. In one this occurred after six weeks; in the other, after two months. A second course of treatment was given to both patients with a return to the normal state.

Prostatic Cancer

Two cases of prostatic cancer are being treated with chlorotrianisene. One patient is 66 years of age and the other is 79. The dosage is 12 milligrams daily and the initial relief of symptoms was observed within 5 to 14 days in both cases. There was an increase in strength and both patients have become ambulatory since therapy was begun. The period of observation is now four months and both cases are free of symptoms at the time of writing.

SIDE EFFECTS

THIS preliminary report is concerned with a total of 33 patients, 31 female and 2 male, treated with chlorotrianisene in daily doses of 12 to 48 milligrams for 7 days to 4 months. There have been no side effects ascribed to the drug. Nausea has been notably lacking.

SUMMARY AND CONCLUSION

CHLOROTRIANISENE is a new estrogenic compound that is relatively free from effects upon other endocrine organs. In 33 patients, preliminary clinical results have been encouraging in the treatment of the menopausal syndrome, postpartum engorgement of the breast, postpartum atonia of the breast, and prostatic cancer. Chlorotrianisene has been effective and side reactions have not been encountered.

Richmond and Forman Avenues

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Aortic Commissurotomy

Dr. Charles Bailey,* who pioneered mitral commissurotomy for rheumatic heart disease, has recently described a surgical approach to the problem of aortic stenosis. Rheumatic involvement of the aortic valve occurs next in frequency to mitral valve involvement. In both instances the major end result is valvular stenosis. There is early appearance of rheumatic vegetations along the lines of valve closure. This is followed by fibrosis along the free edges.

In contradistinction, the arteriosclerotic form of aortic stenosis is characterized by a hardening of the valve leaflets and deposition of calcium salts. There is characteristically no fusion of the commissures. In such cases commissurotomy is not possible.

The technic of aortic commissurotomy described by Dr. Bailey and his associates consists in approaching the valve either through

the aorta itself or from below, via the left ventricle. A special triradiate dilator head is inserted into the valve lumen and when this dilating head is expanded the commissures are separated.

In sixty-two patients operated on by this technic the mortality has been 17.7 per cent. However these patients were very ill or even nearly terminal. More than one half of them had coexisting mitral valve lesions.

Bailey's work is evidence of a continuing surgical approach to rheumatic heart disease. Although many details have to be worked out and the mortality rate reduced to a level far lower than it is now, aortic commissurotomy must be considered another possible method of treatment for rheumatic aortic stenosis.

* Bailey, C. P., *et al.*: Commissurotomy for Aortic Stenosis. *Circ.* 9:22, Jan. 1954.

Traumatic Cancer

Trauma as a possible cause of malignancy is carefully explored in this illuminating review of the pertinent literature.

IT is doubtful whether in any compensation or liability litigation, the petitioner gets a less sympathetic hearing than when he claims that a cancer has developed from a single trauma. Medical testimony in compensation trial records discloses a surprising lack of knowledge by many physicians concerning authoritative findings and opinions indicating the occasional existence of an etiologic relationship between trauma and cancer. A recent article¹ in our state journal has attempted to exclude rigorously even the remote possibility of such a relationship and has deprecated attempts to seek compensation on the basis of traumatic cancer.

Although it is granted that traumatic cancer is rare, the possibility of rendering an injustice to even an occasional worthy claimant makes it imperative to assess carefully evidence supporting the existence of cancer caused by trauma. Let us therefore look at the other side of the coin.

The common experience of physicians indicates that cancer as a result of trauma is rare. Lewy found 37 well-attested malignant tumors in 26,389 injuries. Leclercq² reviewed French statistics and found 5 or 6 traumatic tumors in 100,000 injuries. It is obvious that to be established as more than coincidental, the relation of trauma to tumor must be studied carefully in each case. Segond's³ postulates have been accepted widely by courts both in this country and abroad and also by oncologists as a valuable guide in assessing this problem.

THESE postulates are:

- 1.) The authenticity of trauma to the part must be established definitely.
- 2.) The trauma must be a significant one.
- 3.) There must be reasonable evidence of the integrity of the part prior to the injury.
- 4.) The site of the tumor must correspond to the site of the injury.
- 5.) The date of appearance of the tumor must not be too remote from the time of accident to be associated reasonably with it.
- 6.) The diagnosis of the tumor must be established by clinical, roentgen and, whenever possible, microscopic evidence.

Pack⁴ has added a further limitation to these classic postulates—the cellular character of the sarcoma should be of a relatively simple type; that is, it should consist of primitive cell types such as fibrous, synovial or fat cells which “have probably reacted to injury, hemorrhage, loss of continuity of structure by reparative hyperplasia which in rare circumstances has become neoplastic, even malignant.” The courts have in addition stressed the requirement of continuity of symptoms from the injury to the onset of tumor. These are usually referred to as bridging symptoms for they bridge the temporal hiatus between the trauma and the development of a tumor subsequent to and at the site of the trauma.

THE views of Ewing⁵ concerning the etiologic relation between trauma and cancer are most illuminating. He is not as insistent upon bridging symptoms as are many of the courts. He states that a reasonable time between an injury and the appearance of a tumor caused by it is "from 3 weeks to 3 years or more in certain cases." "Rigid rules," he comments, "may not be enforced regarding the interval between the injury and the appearance of the tumor. There are remarkable cases of acute traumatic sarcoma in which there is almost unbroken continuity of symptoms of injury and malignant tumor. Usually there is an interval of days or weeks when the symptoms of injury subside, to be followed soon by those of progressive tumor. Such cases are observed with sarcoma of bone, in which the remarkable regenerative powers of the periosteum and blood vessels of bone furnish a partial explanation."

Ewing⁶ further finds that trauma is often the exciting cause of exostoses. He recognizes that traumatic myositis ossificans may go on to a traumatic sarcoma although it usually remains an inflammatory muscle process and says,⁷ "... I have often observed the two conditions combined." On page 276 of his text appears the following: "Many clinical observations point to the development of sarcoma from granulation tissue and the histological study of granulation tissue and of organizing blood clots occasionally reveals pictures which closely approach the structure of sarcoma. Von Heuvelom has traced in considerable detail the gradual transformation of the cells of granulation tissue into sarcoma cells. Occasionally one finds small tumors following trauma and containing much blood pigment, of which the structure is distinctly sarcomatous."

HE CONSIDERS that "The reactions of bone to injury give evidence favoring the theory that trauma may be the essential cause of certain benign and malignant tumors of bone." While admitting that the general etiology of bone sarcoma is not attributable to trauma, he concludes,⁸ "... there are on record a substantial number of well-attested cases in which the relation to trauma is very circumstantial,

and the traumatic origin must be accepted." The author has kept close to the direct words of Ewing because he has heard prominent medical experts, some holding professorial rank, testify that they were thoroughly familiar with Ewing's works and that nothing in them accepted the possibility of any etiologic relation between trauma and cancer.

Coley⁹ states,

There are certain bone processes and benign lesions in which the role of trauma seems more difficult to deny: of these the most conspicuous is benign giant cell tumor of bone . . . Many patients with giant cell tumor have been awarded compensation and we believe, rightly so.

On rare occasions we find an osteogenic sarcoma associated with a previously incurred ossifying hematoma and in such instances it is difficult to dissociate the origin of the sarcoma from the injury which caused the ossifying hematoma . . .

Certain cases of osteochondroma or chondromyxoma have been studied where injury has seemed to initiate a change in the type of tumor to that of chondrosarcoma and occasionally unsuccessful extirpation of such a benign tumor has been followed by recurrence and a transition to a fully malignant chondrosarcoma.

Therefore we believe that injury may play an important part in such transition and as a preventive measure we advocate removal of these tumors when they occur in a location which renders them liable to external injury.

GESCHICKTER and Copeland¹⁰ stress the occurrence even in the adult skeleton of foci of growth "where transitional forms between the development of different tissues persist, each transition presenting a possibility for tumor formation." A study of the case presentations by these authors discloses a significant relation between trauma and subsequent tumor. Thus, in 167 cases of Ewing's sarcoma, 40 had a history of antecedent trauma. They state, "In every case in which trauma was recorded, it was definitely related to the subsequent onset of symptoms. The average lapse of time between trauma and symptoms was approximately five and one-half months, the extremes being a few days and more than a year." In their discussion of fibrosarcoma, 10 cases of the 30 presented had a history of antecedent trauma, and of particular interest, two of these had fractures at the site where sarcoma subsequently developed. Their experience with benign giant cell tumor is similar to Ewing's

for they state, "The usual clinical history given by these patients has a sequence of trauma, pain, tumor and fracture extending over a period of from 2 to 14 months. In some cases in which roentgenograms have been taken immediately after injury and at intervals thereafter, the gradual development of the areas of bone destruction can be traced. These cases furnish strong evidence of the etiologic role played by injury for they show that the trauma took place prior to the development of the defect in the bone."

SEELIG¹¹ lists three personally observed cases of single trauma cancer in his extensive experience at the Barnard Free Skin and Cancer Hospital. One case is so typical of most recorded instances of single trauma cancer that it may be summarized with profit. A man struck his shin violently against a steam pipe, developing a hematoma. X-rays were taken and were negative. The post-traumatic swelling and pain persisted and in a few months an osteosarcoma developed at this site and led to his death. Seelig, who is director of pathology at the Barnard Hospital and professor of clinical surgery at Washington University School of Medicine states: "In my own experience, I have seen enough to know that in properly selected instances, few in number 'tis true, the conclusion is unavoidable that one trauma seems to evoke a subsequent cancer."

Pack⁴ describes four personally observed cases of single trauma cancer. The tumors were all sarcomas—fibrosarcoma, malignant synovionoma and liposarcoma.

Stewart,¹² in an article on occupational tumors, lists ten types of cancer which are clearly related to an industrial hazard but does not accept the possibility of trauma causing cancer. He considers that injuries are too frequent and sarcomas too rare to admit of any relationship and notes that surgeons traumatize bone severely in some therapeutic procedures without causing development of a sarcoma. A manifest error of logic is involved in reasoning that because an occurrence is rare, it follows that it cannot and does not happen.

Certainly fat embolism is rare after major traumatizing procedures on bone, yet we cannot deny its existence or its cause because of its rarity. Indeed, Pack⁴ has reported the extremely unusual occurrence of sarcoma developing from a surgical scar, and as is well known, the development of keloids in such scars is quite common.

LEIGHTON¹¹ lists 13 cases of single trauma cancer and refers to over one hundred more in the literature.

Levinson and Furst¹³ of Newark, writing in this journal, describe two cases of malignancy caused by trauma. One of these fits into the most common pattern of single trauma cancer. A worker was struck on the inner part of the left thigh by a 100 pound can and developed a hematoma at this site. Seven months later a cystic mass removed from this location was found to contain old and fresh blood. Microscopic examination of the tissue disclosed a synovial sarcoma.

Additional recently reported cases¹⁴ of traumatic cancer include a traumatic osteosarcoma of the left sacroiliac area, a post-traumatic osteosarcoma of the humerus and a traumatic fibrosarcoma of the calf. The medico-legal abstracts section of the Journal of the American Medical Association over an eleven-year period contains five cases in which compensation awards were granted for traumatic cancer.¹⁵ All of these were sarcomas.

COMMENT

EVEN from this brief survey of the literature, it is evident that a substantial body of authoritative opinion and a considerable number of proved cases indicate that trauma may occasionally cause cancer. Yet a study of testimony by medical experts for insurance carriers in this type of compensation litigation shows a surprising ignorance or mental block concerning the studies herein reviewed. In New Jersey such testimony may be decisive since state law places the petitioner in workmen's compensation suits at a definite disadvantage in engaging medical witnesses to appear in his behalf. Fees for all medical wit-

nesses are limited to \$150 in any one case and the sum payable to any one witness is within the discretion of the referee but may not be more than \$50. The law¹⁶ is silent regarding out-of-state witnesses. Contrasted to this, no limit is placed on the fees paid by the respondents to the medical witnesses appearing on their behalf and the payment is not based on contingency. As a result, the most practiced and convincing medical experts, including some with impressive academic affiliations, find frequent and remunerative employment testifying for respondents.

It is unfortunate that the complicated factors discussed by the medical expert witnesses are evaluated by persons who, though they may be skilled in the law, have no medical training and are therefore simply not equipped to analyze the complex and conflicting testimony of medical experts. It seems obvious that the merits of the medical arguments in such cases should be decided by physicians. This would have the further salutary effect of tempering the frequent partisan approach of medical witnesses to the questions involved. To introduce such a change in the courts entails a lengthy and difficult procedure but at least a start should be made in this direction. The

appointment of a panel of medical experts to act in a non-judicial capacity as friends of the court would be one solution. Shindell¹⁷ has advised a pre-trial board examination of the medical facts in a case by a panel composed of qualified physicians and attorneys. The problem is important enough to warrant further study by joint committees of the medical societies and bar associations and by representatives of the unions, the insurance carriers and the general public.

CONCLUSION

AUTHORITATIVE opinion and numerous well-attested cases disclose that trauma can cause cancer in rare instances. Well-accepted criteria have been established which must be met in determining the probable relation of trauma to cancer and these have been accepted by scientists and by the courts. The denial of the possibility of such a relationship between trauma and cancer may render an injustice to a worthy claimant. The problem is frequently a medicolegal one and in such cases conflicting medical testimony is baffling to the courts and to juries and should be evaluated by impartial medical experts.

1616 Pacific Avenue

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HAROLD J. MUENDEL, M.D.*

Basking Ridge

MICHAEL PILPEL, M.D.**

Plainfield

Rupture of Aortic Aneurysm with Duodenal Hemorrhage

A case of aortic aneurysm rupturing into the duodenum is described.

ATHEROSCLEROTIC aneurysm of the abdominal aorta with dissection and rupture into the duodenum resulting in massive intestinal hemorrhage is rare.^{1,2,3,4}

Bagnuolo and Bennett² in 1950 reviewed the literature as far back as 1843 and found 111 cases of non-traumatic perforation of the aorta into the gastro-intestinal tract. Sixty were secondary to ulcerating carcinomas of the esophagus and 45 due to invasion by an aortic aneurysm of the stomach, duodenum, or jejunum. Of these 45, 36 ruptured into the third portion of the duodenum. Coggeshall and Genovese¹ in 1950 independently reviewed the literature and collected a total of 49 cases of aortic aneurysm entering the duodenum. They reviewed the reports of Rottino³ (32 cases) and Hunt and Weller,⁴ (9 cases) and added 9 cases, including their own, to bring the total to 50 cases. Massive hemorrhage occurred into the duodenum in 72 per cent, into the stomach in 14 per cent, and into the jejunum in 14 per cent.

The following report describes the rupture

of an atherosclerotic aneurysm of the abdominal aorta into the third portion of the duodenum.

CASE REPORT

This 63-year old white male was admitted on December 12, 1930, and hospitalized more or less continuously since then with schizophrenic reaction, hebephrenic type, chronic, severe. On his admission, an x-ray of the chest revealed pulmonary tuberculosis in the right apex, which was felt to be inactive. The patient showed no change in his physical status for the next twenty years. Most of the time he presented the picture of a deteriorated schizophrenic.

In 1947 it was noted that the patient began to have frequent rises in temperature, to 100 degrees F., with a slight increase in the sedimentation rate. Chest x-ray showed a lesion extending from the apex down to the first rib on the right side, predominantly fibrotic. There was some pleural thickening and a deviation of the trachea to the right. The patient was observed closely at this time with serial x-rays and sputa studies. When these continued to be negative and unchanged in the following years, the patient's tuberculosis was considered inactive.

However, a routine x-ray of the chest on December 12, 1951, revealed scattered productive and calcific infiltrations with high-lights in the infraclavicular region resembling honey-combed lung. These findings appeared more extensive than on previous studies and the patient was therefore transferred to the tuberculosis service for further observation. Examination at this time revealed a well developed, elderly, white male, well nourished, and not appearing acutely or chronically ill. There were dimin-

* Chief, Surgical Service, Veterans Administration Hospital, Lyons, N. J.

** Staff Physician, Veterans Administration Hospital, Lyons, N. J.

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ished breath sounds over the right upper lobe, with moist rales scattered throughout the right lung. The heart sounds were of good quality, without murmurs, or thrills. The blood pressure was 120/68. Electrocardiograms at this time and previously were interpreted as being not diagnostic by the cardiologist. The abdomen revealed no tenderness, rigidity or masses palpable. There were herniorrhaphy scars in both inguinal regions. There were minimal varicosities of both lower extremities. The prostate was slightly enlarged, but not painful on pressure. The remainder of the physical examination was essentially non-contributory. Urinalysis revealed a specific gravity of 1.020, rare WBC, negative sugar and albumin. Red blood count was 4,620,000 with 14.4 grams of hemoglobin, white blood count, 8,500 with 63% neutrophils, and 34% lymphocytes. Blood urea nitrogen 19.2 mg. per cent; hematocrit 42; bromsulfalein 6%; cephalin flocculation negative in 24 hours, and 3 plus in 48 hours. Sputa were negative on smear, but positive once on culture. The patient was placed on combined streptomycin and para-amino-salicylic acid, but this had to be discontinued because of nausea, vomiting and gastrointestinal disturbances. During these months, the patient remained afebrile, with a normal pulse and no loss of weight, or other evidence of clinical progression.

On July 1, 1952 he was treated with Nydrazide, 50 mg. TID. Laboratory tests prior to this regime were all within normal limits except for a slight elevation of sedimentation rate. A review of the patient's case by the Chest Board on August 25, 1952, revealed no change in the lung findings by x-ray, but the patient appeared to be doing well clinically, gaining weight with no fever. During these months of Nydrazide® therapy, he did complain of pain in the abdomen, which he claimed became worse on eating. He also stated that he vomited if he took too much food at one time. Despite these incidences, he maintained his weight and there was no further notation of abdominal discomfort.

On the morning of September 26, 1952, the patient complained of vomiting during the night. He appeared pale and had a weak pulse. Within a short time (8:30 a.m.) he was found to have fainted. At 9:00 a.m. he had a severe rectal hemorrhage. His blood pressure was 80/42. One thousand cubic centimeters of plasma and 500 cc. of whole blood were given as soon as available, but the patient's respirations became more labored, his pulse more rapid and thready, and his color paler. His abdomen was soft to palpation and there was no tenderness, rigidity, or palpable masses. The patient expired at 12:30 p.m.

Pathology: The pertinent findings at autopsy included fibro-caseous pulmonary tuberculosis, with cavitation in the right upper lobe; atherosclerotic aneurysm of the abdominal aorta, with dissection anteriorly and rupture into the duodenum, with resultant massive intestinal hemorrhage. The thoracic aorta presented remarkably few atherosclerotic plaques, but an increasing number of plaques were evident distally. Below the diaphragm the plaques became larger and slightly elevated, with puckering of the aortic endothelium between the plaques. The branches of the upper abdominal aorta showed no change at their origins. Just distal to the right

renal artery the aorta widened cylindrically to a diameter of 6 centimeters. This dilatation extended to the bifurcation. In situ, it presented a very firm mass. When opened, the lumen of the vessel was markedly widened and filled with clots of various ages. About 2.5 centimeters from the right renal artery a rent in the wall of the anterior portion of the aorta communicated with the overlying third portion of the duodenum. The perforation into the duodenum was linear and measured 2 centimeters in length. Exposure on the intestinal side gave the appearance of a large berry, purplish red. The surrounding mucosa was entirely intact.

On section, the aorta exhibited destruction of the intima and media, with some sections showing intimal atheromatous changes. In the adventitia there was an extensive round cell infiltration with giant cells and histiocytes resembling epithelioid cells. The adjacent necrosis was continuous with that through the wall of the aorta and resembled caseation, but acid fast bacilli were not noted. No further evidence of tuberculosis could be found on serial sections.

COMMENT

*P*ERFORATION occurs most often in the third portion of the duodenum where there is anatomic apposition with the abdominal aorta in the retroperitoneal space.

Bagnuolo and Bennett² report a case where perforation of the aorta was on a tuberculous basis with perforation into the esophagus and right lung. In our case the adventitia of the abdominal aorta showed some round cell infiltration with giant cells and histiocytes resembling epithelioid cells. This adjacent necrosis, which was continuous with the atheromatous necrosis through the wall of the aorta resembled caseation, but acid fast bacilli could not be found nor other evidence of tuberculosis on serial sectioning.

The usual clinical picture of abdominal aortic aneurysm is one of a tumor which shows expansile pulsations. An x-ray will show a calcified abdominal mass or an indefinite soft tissue mass, sometimes even vertebral erosion. In addition, the aneurysm may be first suspected during a vascular crisis or a state of shock. Massive intestinal hemorrhage is 100 per cent fatal.

SUMMARY

*M*ASSIVE gastrointestinal hemorrhage from an atherosclerotic aneurysm of the abdominal aorta, with dissection anteriorly and rupture

into the third portion of the duodenum is reported. According to the literature, including the one presented, there are 37 known cases. This is usually a terminal event. However, it

has been reported that some cases do linger after the first sign of massive hemorrhage, and in selected cases emergency surgical intervention may be indicated.

Madisonville Road

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Friedlander Bacillus in Respiratory Disease

Klebsiella pneumoniae is widely recognized as a cause of acute pneumonia which is usually fulminating and carries a high mortality rate.

Fulton and McKinlay* have reported eight cases of chronic respiratory disease (bronchitis and sinusitis) in which the Friedlander bacillus was isolated from the sputum. The correct etiology was suspected by previously unsuccessful treatment with penicillin and the raising of a peculiar green foul-smelling sputum. In some instances a change in the appearance of the sputum from yellowish to green while the patient was receiving antibiotics

prompted a recheck of the sputum culture and the demonstration of the Friedlander bacillus.

Once this bacillus is isolated it is necessary to do resistance studies to determine which antibiotic is effective. In the eight cases reported complete resistance to penicillin was found. In seven of the eight, treatment was satisfactory when the appropriate antibiotic was used. The single failure was a patient with bronchiectasis.

*Fulton, J. K. and McKinlay, B. C.: Role of the Friedlander Bacillus in Chronic Respiratory Disease. *Ann. of Med.* 40:245, February 1954.

Probenecid in Tuberculosis

Probenecid alters the metabolism or excretion of PAS so that the concentration of free PAS in the blood stream is increased.

Studying experimental tuberculosis in guinea pigs, Carr and Karlson,* at the Mayo Clinic, have demonstrated that the administration of probenecid with PAS enhances the therapeutic effect of PAS in experimental tuberculosis. These authors suggest that a clinical study of

the combination of these drugs be undertaken to determine if experimental studies can be confirmed in humans.

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Emergency Medical Service, Civil Defense	R. Winfield Betts, Medford
Medical School	Stuart Z. Hawkes, Newark
Physicians Placement Service	Marcus H. Grefinger, Newark
Medical Research	Ray E. Trussell, Flemington

Trustees' Meeting

January 10, 1954

(Minutes approved April 4, 1954)

A REGULAR meeting of the Board of Trustees was held on Sunday, January 10, 1954, at the Executive Offices, Trenton. The following is a summary of the principal actions taken at this meeting:

Dr. William Braun of Camden was appointed by the chairman, Dr. Reuben L. Sharp, as the representative of the Society on the Consulting Board of the New Jersey Commission for the Blind on the Glaucoma Follow-up Service.

In response to inquiries submitted by the Scientific Program Committee concerning the number of out-of-state speakers permitted to participate in section meetings at the annual convention, the Board adopted the following motion: Scientific Program Committee may

permit sections to invite one or two out-of-state speakers, the decision to be dictated by circumstances, and made by the section chairman. This action is to be effective beginning with the 1955 annual meeting.

In connection with its acceptance of the report of the President, the Board granted approval to the following:

Transmittal of a letter to Governor Meyner approving the request of the New Jersey State Commission for the Blind that the second week of February be proclaimed "Glaucoma Detection Week."

Designation of Dr. Arthur F. Mangelsdorff, chairman of the Advisory Committee on Workmen's Compensation and Industrial Health, as

the official representative of the Society on the State Health Department's Advisory Committee on Adult and Industrial Health.

Appointment of Dr. Sol Parent and Dr. John Novak as members of the Medical Advisory Committee to the New Jersey Society for Crippled Children and Adults.

A MOTION was adopted authorizing the establishment of an Annual Report Review Committee. Its function would be to review all annual reports from agencies within the Society and to ascertain that they have cleared through proper channels and that recommendations which they contain are all in order. The chairman then named the following as members of the Annual Report Review Committee: Dr. Albert B. Kump, chairman; Dr. Luke A. Mulligan, and Dr. David W. Green. Dr. Henry B. Decker, President and Dr. Marcus H. Greifinger, Secretary, were named members *ex-officio*.

In connection with its acceptance of the report of the Executive Officer, the Board took the following actions:

A motion was adopted to establish a Special Committee on Veterans Medical Services to consist of three members of the State Society, with Dr. Irving P. Borsher acting as adviser. Subsequently the committee was designated as follows: Dr. Harrold A. Murray, chairman; Dr. C. Byron Blaisdell, and Dr. Albert B. Kump.

Approval was granted to the continuance of affiliation with the New Jersey Council of Professions; it was directed that five delegates should be named to participate in the Council, and that these delegates should be designated by position. The delegates so named are: Dr. David B. Allman, member of State Board of Medical Examiners; Dr. C. Byron Blaisdell, chairman, Subcommittee on Legislation; Dr. Frank S. Forte, chairman, Subcommittee on Public Relations; Dr. Kenneth E. Gardner, chairman, Subcommittee on Public Health; Dr. Rudolph C. Schretzmann, chairman, Subcommittee on Medical Practice.

*T*HE Executive Officer informed the Board that requests have been received from com-

mittee chairmen for verbatim transcriptions of the entire proceedings of meetings. He gave his opinion that a concise summary would be much more helpful to the members of the committees. The Board authorized the Executive Officer to prepare the minutes of meetings held in the Executive Offices in the form most consonant with efficient service to the committees and efficient utilization of the staff and the office facilities.

The Board unanimously adopted a resolution on the death of Dr. Joseph F. Londrigan prepared by Dr. Vincent P. Butler, and stood in silence for a minute as an expression of its grief at his passing.

The Medical-Surgical Plan requested direction as to whether it should proceed with the preparation of its proposed new contract without provision for consultation services at this time, looking to the inclusion of consultations subsequently, when qualifying criteria for specialists are prepared and approved. A motion was unanimously adopted by the Board declaring that the Board realizes that it is impossible at this time to include consultations in the new contract and directs that the Medical-Surgical Plan proceed with the preparation of its proposed new contract without including provision for consultations, but with the understanding that such provision shall be made as soon as feasible.

*T*HE Board appointed Dr. David B. Allman as official representative of the State Society at the Fiftieth Annual Congress on Medical Education and Licensure, held in Chicago on February 7-9.

The Board accepted from Dr. Albert B. Kump a silver pitcher donated by Dr. Kump, Dr. Carl N. Ware, and Dr. Mary Bacon of the Cumberland County Medical Society in memory of Dr. Joseph F. Londrigan. In making the presentation Dr. Kump declared that the donors wanted to offer a tribute to Dr. Londrigan which would perpetuate his memory among the members of *The Medical Society of New Jersey* as one who worked long and diligently for its advantage. President Decker responded in behalf of the Board and the Society and thanked Dr. Kump for the gift.

188th Annual Meeting — May 16-19, 1954

Official Attendance

County	Delegates	Members	Total
Atlantic	10	75	85
Bergen	27	39	66
Burlington	4	15	19
Camden	16	50	66
Cape May	3	8	11
Cumberland	5	21	26
Essex	64	163	227
Gloucester	4	7	11
Hudson	23	47	70
Hunterdon	3	4	7
Mercer	22	59	81
Middlesex	12	42	54
Monmouth	9	64	73
Morris	12	27	39
Ocean	3	8	11
Passaic	29	43	77
Salem	3	4	7
Somerset	5	14	19
Sussex	2	2	4
Union	32	60	92
Warren	2	3	5
Fellows, Officers, Trustees, Councilors	18	—	18
	308	760	1,068

Physician Guests	114
Physician Exhibitors	49

TOTAL PHYSICIAN REGISTRATION . . . 1,231

Auxiliary Members	389
Visitors	356
Exhibitors	251

TOTAL REGISTRATION . . . 2,227

SEVEN YEAR COMPARATIVE REGISTRATION FIGURES

	Physicians	Others	Total
1954	1,231	996	2,227
1953	1,012	871	1,883
1952	1,010	785	1,795
1951	865	699	1,564
1950	1,019	851	1,870
1949	1,073	782	1,855
1948	1,099	774	1,873

Scientific Exhibit Awards

Class I—Scientific exhibits of individual investigations, judged on the basis of originality and excellence of presentation:

First Award: Non-surgical Cholangiography
William H. Shehadi, M.D., New York Poly-
clinic Medical School and Hospital, New
York, N. Y.

Second Award: Recurrent Intestinal Obstruc-
tion: A New Method of Treatment

Victor P. Satinsky, M.D. and Samuel D.
Kron, M.D., Einstein Medical Center, Phil-
adelphia, Pa.

Third Award: Clinical Correlation of Allergic
Symptoms and Mold Content of Air and
House Dust

Nathan Schaffer, M.D., Orange Memorial
Hospital, Orange, N. J.; East Orange Gen-
eral Hospital, East Orange, N. J. and Ed-
ward E. Seidmon, M.D., Hunterdon Medi-
cal Center, Flemington, N. J.; Muhlenberg
Hospital, Plainfield, N. J.

Honorable Mention: Visceral Granuloma due
to Migrating Larvae of *Ascaris Lumbricoi-
des*

T. K. Rathmell, M.D., J. Mora, M.D., and
P. Volodkevich, M.D., Department of
Pathology, Mercer Hospital, Trenton, N. J.

Class II—New Jersey Exhibitors:

First Award: Clinical Observations on Por-
tal Cirrhosis

Carroll M. Leevy, M.D., Myra R. Zinke,
M.D., Thomas J. White, M.D., Angelo M.
Gnassi, M.D., and Felix Traugott, Medical
Center, Jersey City, N. J.

Second Award: Modern Therapy of Chronic
Alcoholism

Marvin C. Becker, M.D., Beth Israel Hospi-
tal, Newark, N. J., Ebbe C. Hoff, M.D. and
J. David Markham, M.D., Division of Alco-
hol Studies and Rehabilitation, Medical Col-
lege of Virginia, Richmond, Virginia.

Third Award: Pathology of the Ureter

I. Maisel, M.D. and M. Malament, M.D.,
East Orange Veterans Hospital, East Or-
ange, N. J.

Honorable Mention: Intra-articular Hydro-
cortisone

John W. Gray, M.D. and Evelyn Z. Mer-
rick, M.D., Newark, N. J.

With New Jersey Medical Authors

This listing of New Jersey contributions to the medical literature includes published writings beginning with January, 1954. It will not be possible to attempt a listing of the publications by New Jersey authors appearing in the interval between the date of the last previous listing up through December, 1953. For the future it shall be our policy to scan journals as they are checked in by this library (Academy of Medicine of New Jersey Library, Newark). Omissions noted in this and future listings may result either from the fact that the library does not receive the journal in which the contribution appeared or, possibly, through faulty scanning. It is suggested that such omissions be brought to the attention of the undersigned compiler for subsequent listing.

Harold M. Goettel, Librarian
Academy of Medicine of New
Jersey Library
91 Lincoln Park
Newark 5, New Jersey

- Albright, Louis F. (Point Pleasant) and Brown, Frank J.—Acute myocardial infarction associated with acute porphyria. *Am. Heart J.* 47:108, January 1954.
- Antonius, Nicholas A. (Newark), Ralph Miller, Henry Green and Anthony D. Crecca—Mitral stenosis; surgical therapy from the practitioner's viewpoint. *Postgrad. Med.* 15:11, January 1954.
- Bernstein, Arthur (Newark)—see Skwirsky, Joseph.
- Brown, Frank J. (Point Pleasant)—See Albright, Louis F.
- Brunner, Hans (Newark)—Attachment of the stapes to the oval window in man. *A.M.A. Arch. Otolaryng.* 59:18, January 1954.
- Cohen, Herman (Trenton), Henry H. Freedman, William Kleinberg, Norman R. Schechter and Gustav J. Martin—Enhancement of corticotrophic activity: effect on adrenal and thymus weights. *Endocrinology* 54:81, January 1954.
- Connell, John N. (Jersey City)—Diabetes mellitus in pregnancy complicated by hydramnios and toxemia: case report. *Bull. Margaret Hague Hosp.* 7:25, March 1954.
- Cosgrove, Robert A. (Jersey City), Edward G. Waters and Martha Loving—Abdominal paracentesis uteri in the management of hydramnios: report of 3 cases. *Bull. Margaret Hague Hosp.* 7:11, March 1954.
- Crecca, Anthony D. (Newark)—See Antonius, Nicholas A.
- Cutler, Milton (Hammonton) and Paul Cutler—Iatrogenic meningitis. *Digest Ophth. & Otolaryng.* 16:160, January 1954.
- Cutler, Paul (Hammonton)—See Cutler, Milton
- Demy, Nicholas G. (Plainfield) and Aaron P. Gewanter—Correlation of upper lobe vascularization with certain congenital intracardiac shunts. *Radiology* 62:329, March 1954.
- Drake, Miles E. (Vineland) and Charles Ming, B. S.—The danger of serum hepatitis associated with the improperly supervised routine laboratory collection of bloods. *Am. J. Ment. Deficiency* 58:436, January 1954.
- Dvorschak, Carl K. (Jersey City)—See Leevy, Carroll.
- Felmy, Lloyd M. (Jersey City)—See Loving, Martha.
- Fine, Irvin J. (Perth Amboy)—Goldman technic in nasal septal surgery. *A.M.A. Arch. Otolaryng.* 59:141, February, 1954.
- Finkler, Rita S. (Newark)—Sex steroids and cancer. *J. Am. M. Women's A.* 9:7, January 1954.
- Flicker, David J. (Newark)—See Levison, William.
- Gelb, Jerome (Newark)—See Kessler, Henry H.
- Gendreau, Alvin (Jersey City)—See Hamel, Joseph.
- Gerendasy, Julius (Elizabeth)—Surgical principles in the treatment of anorectal disease. *Am. J. Surg.* 87:195, February 1954.
- Gewanter, Aaron P. (Somerville)—See Demy, Nicholas G.
- Glasser, John W. H. (Fairlawn) and Edward G. Waters—Changing concepts of third and fourth degree extensions. *Bull. Margaret Hague Hosp.* 7:17, March 1954.
- Gnassi, Angelo M. (Jersey City)—See Leevy, Carroll.
- Goldman, Lester M. (Newark)—See Tillis, Herman H.
- Green, Henry (Newark)—See Antonius, Nicholas A.
- Hamel, Joseph (Jersey City) and Alvin Gendreau—Report on Cesarean sections during 1952. *Bull. Margaret Hague Hosp.* 7:28, March 1954.
- Henle, Carye-Belle (Newark)—The management of endometrial carcinoma. *J. Am. M. Women's A.* 9:11, January 1954.
- Kessler, Henry H. (Newark) and Jerome Gelb—Pectoral cineplasty. *Plast. & Reconstruct. Surg.* 13:10, January 1954.
- Kessler, Henry H. (Newark) and Herbert M. Simonson—Procedure for cutting the stem of a vitallium hip prosthesis. *J. Bone & Joint Surg.* 36-A:158, January 1954.
- Leevy, Carroll (Jersey City), Carl K. Dvorschak and Angelo M. Gnassi—The liver in extrahepatic biliary obstruction. *Am. J. M. Sc.* 227:272, March 1954.
- Levine, Philip (Raritan) and Morton Grove-Rasmussen—Occurrence of anti-D and anti-E in absence of obvious antigenic stimuli. *Am. J. Clin. Path.* 24:145, February 1954.
- Levine, Philip (Raritan), Elizabeth A. Koch, M.S., Robert T. McGee, B.A., and Glen H. Hill—Rare human isoagglutinins and their identification. *Am. J. Clin. Path.* 24:292, March 1954.
- Levison, William (Newark), David J. Flicker, Mildred G. Mayne and Joseph Skwirsky—The uncooperative diabetic. *J. Newark Beth Israel Hosp.* 5:3, January 1954.

- Lohman, Herman (Newark)—Aneurysmal bone cyst; report of a case in the scapula. J. Newark Beth Israel Hosp. 5:51, January 1954.
- Loving, Martha (Jersey City) and Lloyd M. Felmly—Hospital Statistics for 1952. Bull. Margaret Hague Hosp. 7:23, March 1954.
- Loving, Martha (Jersey City)—See also Cosgrove, Robert A.
- Meyer, George P. (Camden) and B. A. Gross—Ocular examination in diagnosis of congenital syphilis. Am. J. Syph. 38:30, January 1954.
- Miller, David B. (Princeton)—Chyle cyst of the mesentery; brief review and report of case in a three-week-old infant. A.M.A. Arch. Surg. 68:359, March 1954.
- Miller, Ralph (Newark)—See Antonius, Nicholas A.
- Muehsam, Gerald E. ((South Orange) and George J. Magovern—Calcification of the portal and splenic veins. Am. J. Roentgenol. 71:84, January 1954.
- Peer, Lyndon A. (Newark)—Autogenous bone transplants in humans. Plast. & Reconstruct. Surg. 13:56, January 1954.
- Read, Jessie D. (Westfield) and Ray F. Chesley, B. S.—Vaginal cytology as an office procedure; report of a six year survey. Bull. Margaret Hague Hosp. 7:1, March 1954.
- Riese, Jacob A. (West New York)—Clinical comparison of four anticholinergic drugs. Am. J. Digest. Dis. 21:81, March 1954.
- Schaaf, Royal S. (Montclair)—Cardiovascular diseases; a review of some significant publications (July 1949—June 1952). With the editorial assistance of Edward F. Bland. (Progress in Internal Medicine section) A.M.A. Arch. Int. Med. 93:254, February 1954; 93:407, March 1954.
- Schaffer, Nathan (East Orange)—See Seidmon, Edward E. P.
- Seidmon, Edward E. P. (Plainfield) and Nathan Schaffer—Cortogen nasal suspension with Chlortrimeton in the treatment of allergic rhinitis. Ann. Allergy 12:85, January—February, 1954.
- Simon, Franklin (Newark)—See Skwirsky, Joseph.
- Simonson, Herbert M. (Newark)—See Kessler, Henry H.
- Singer, Milton (Newark)—A survey of lymph node biopsies at the Newark Beth Israel Hospital, 1936-1952. J. Newark Beth Israel Hosp. 5:29, January 1954.
- Skwirsky, Joseph (Newark), Arthur Bernstein and Franklin Simon—Idiopathic ventricular hypertrophy; case report. J. Newark Beth Israel Hosp. 5:37, January 1954.
- Skwirsky, Joseph (Newark)—See also Levison, William.
- Snyder, William (Paterson)—Simple distance-measuring and centering device for x-ray therapy machine. A.M.A. Arch. Dermat. & Syph. 69:374, March 1954.
- Susinno, A. M. (Palisades Park) and R. E. Verdon—Results of treatment of calcific tendinitis with adenosine 5-monophosphate; preliminary report. Clinical notes section. J. A. M. A. 154:239, January 16, 1954.
- Tillis, Herman H. (Newark) and Lester M. Goldman—Effect of long-continued cortisone therapy on the bone marrow of rheumatoid patients. J. Newark Beth Israel Hosp. 5:23, January 1954.
- Verdon, Robert E. (Cliffside Park)—See Susinno, A.M.
- Waters, Edward G. (Jersey City)—See Cosgrove, Robert A.; see Glasser, John W. H.

CONTRIBUTIONS FROM NEW JERSEY RESEARCH LABORATORIES

- Frank, Henry G. and L. Reiner—The action of fatty acids on *Trichomonas Vaginalis*. J. Immunol. 72:191, February 1954. (Wallace and Tiernan Company, Belleville)
- Gaunt, Robert, J. H. Leathein, Constance H. Tutthill, Nancy Antonchak, Martha Gilman and A. A. Renzi—Some biological properties of aminosteroids. Endocrinology 54:272, March 1954. (Ciba Pharmaceutical Products, Inc., Summit)
- Hendlin, David and Jeanne C. Wall—Relationship between vitamin B₁₂ oxidation product and sodium chloride toxicity for lactobacilli. J. Bact. 67:38, January 1954. (Merck & Co., Inc., Rahway)
- Ilavsky, Jan.—A new procedure for screening anti-tuberculous agents; effect of chemotherapeutic agents on mice infected with massive doses of tubercle bacilli intraperitoneally. Am. Rev. Tuberc. 69:280, February 1954. (Schering Corporation, Bloomfield)
- Kroc, R. L., G. E. Phillips, N. R. Stasili and S. Malament—Antigoitrogenic and calorogenic assay of thyroglobulin, dessicated thyroid and 1-Thyroxine by different routes of administration in rats. J. Clin. Endocrinol. 14:56, January 1954. (Warner-Chilcott Laboratories, Morris Plains)
- Mayer, R. L. and N. H. Sloane—Factors affecting the hydroxylation of aniline by *Mycobacterium Smegmatis*. J. Biol. Chem. 206:751, February 1954. (Lederle Laboratories Division, American Cyanamid Co., Pearl River, N. Y. and Division of Microbiology, Ciba Pharmaceutical Products, Inc., Summit)
- Schallek, William and Donald Walz—Effects of isoniazid and iproniazid on the central nervous system of the dog. Am. Rev. Tuberc. 69:261, February 1954. (Hoffmann-LaRoche, Inc., Nutley)
- Schneider, Jurg A. and Alfred E. Earl—Effect of O-Methoxyphenylglycerol ether (Resyl) on spinal reflex arcs; with the technical assistance of Robert Moore. Proc. Soc. Exper. Biol. & Med. 85:323, February 1954. (Ciba Pharmaceutical Products, Inc., Summit)
- Schnitzer, R. J. and Dorothy R. Kelly—Interference phenomenon of Browning and Gulbransen in experimental infection of mice with *Trichomonas vaginalis*. Proc. Soc. Exper. Biol. & Med. 85:123, January 1954. (Hoffmann-LaRoche, Inc., Nutley)
- Solotorovsky, Morris and Seymour Winston—Inhibition of fatal anaphylactic shock in the mouse with cortisone. J. Immunol. 72:177, February 1954. (Merck Institute for Therapeutic Research, Rahway)
- Trapold, J. H., A. J. Plummer and F. F. Yonkman—Cardiovascular and respiratory effects of Serpasil, a new crystalline alkaloid from *Rauwolfia Serpentina* Benth, in the dog. With the technical assistance of M. W. Osborne. J. Pharmacol. & Exper. Therap. 110:205, February 1954. (Ciba Pharmaceutical Products, Inc., Summit)

Wells, Philip V., D. Sc.—An improved flarimeter. *Am. Heart J.* 47:102, January 1954. (Medical Dept., Prudential Insurance Company of America, Newark)
Ziegler, J. B., R. E. Bagdon and A. C. Shabica—

The solubility of some sulfonamides of current clinical importance. *Am. J. Digest. Dis.* 21:74, March 1954. (Ciba Pharmaceutical Products, Inc., Summit)

Obituaries • • •

DR. HYMAN I. GOLDSTEIN

Dying in harness, as he would have wished, Dr. Goldstein suffered a fatal coronary attack while participating in a seminar at the University Hospital, Philadelphia, on March 17. He was 66 years old. While he had retired from active practice in 1950, he was still vigorously engaged in research, historical and training activities in internal medicine up to the moment of his death. A native of Baltimore, he came to Camden in childhood. He won a scholarship to the University of Pennsylvania Medical School from which he was graduated in 1909. From 1910 until 1950 he was in active practice in Camden.

Dr. Goldstein was a prolific writer—he published 135 articles in 40 years. He was an active member of a dozen medical organizations. He was chairman of the gastroenterology section of The Medical Society of New Jersey. He was scheduled to be the opening speaker for the International Gastroenterologic Congress in Mexico City which took place a week after Dr. Goldstein's death.

Dr. Goldstein had, for years, served the Board of Education of Camden. He had staff appointments at numerous hospitals in Philadelphia and south Jersey. His major fields of professional interest were gastroenterology and medical history. He was one of the few New Jersey physicians to have won a place in the medical dictionary. He was the first observer of, and eponym for, Goldstein's sign (positioning of the big toe in Mongolian idiocy), and Goldstein's disease (a familial angiomatosis). During most of his professional life he was active in the affairs of the Camden County Medical Society.

DR. GRACE A. HOLMES

Dr. Grace A. Holmes died in Rumson on March 31 at the age of 78.

Dr. Holmes, founder of the Presbyterian Hospital, San Juan, Puerto Rico, also served as president of the Visiting Nurse Association of Eastern Union County for seven years.

A graduate of New York Women's Medical College in 1898, Dr. Holmes began her medical career as a medical missionary in Puerto Rico in 1901. In 1919, after a year of postgraduate study at College of Physicians and Surgeons (Columbia), Dr. Holmes began a practice of gynecology and pedia-

trics in Elizabeth. She was a member of the national and state Women's Medical Associations and the Clinical Society of New Jersey. She had been a member of the staff of Elizabeth General Hospital, and a teacher in the hospital's school of nursing. Dr. Holmes was an Emeritus Member of the Union County Medical Society and The Medical Society of New Jersey.

DR. MORRIS H. LEAVER

Dr. Morris H. Leaver died on April 13 at the Hunterdon County Medical Center at the age of 81.

Dr. Leaver was a graduate of the University of Pennsylvania Dental School, and in 1902 received his medical degree from the University of Pennsylvania Medical School.

During World War I he served in the Army Medical Corps. He was one of the pioneer supporters of the Hunterdon County Center.

Dr. Leaver's career was unique in that he practiced both medicine and dentistry for more than 50 years in Quakertown.

DR. CHARLES S. MILLS

Dr. Charles S. Mills, age 76, died on April 7 in West Jersey Hospital, Camden.

Dr. Mills was graduated from Hahnemann Medical College in 1900 and practiced medicine in Camden for a short time before establishing a practice in Riverton. He was a member of the staff of West Jersey Hospital.

Besides his 50 years of medical practice, Dr. Mills was founder of the Cinnaminson Bank and Trust Company of Riverton, and served as its president since 1946.

DR. RAYMOND J. MULLIN

Dr. Raymond J. Mullin, Newark Police Surgeon and Medical Director of St. James Hospital, died there on April 18 at the age of 65.

Dr. Mullin, a native of Newark, was graduated from the University of Pennsylvania Medical School in 1903. Following graduation he studied pathology at the University of Pennsylvania and then in-

terned in St. Agnes Hospital, Philadelphia, the Philadelphia Municipal Hospital, and Newark City Hospital.

In 1915 Dr. Mullin established his practice in Newark. He served as a captain in the Army Medical Corps during World War I, as Assistant Police Surgeon 1921-1933, and as Police Surgeon from 1933 until his death.

Dr. Mullin was also on the staff of the Martland Medical Center and past president of its medical board. He was a member of the Doctors' Club and Essex County Anatomical and Pathological Society, of whose Board of Governors he was former president.

DR. SIDNEY B. RAWITZ

Dr. Sidney B. Rawitz, age 63, died on March 25 in Fitkin Memorial Hospital, Neptune.

Dr. Rawitz was a graduate of Loyola Medical School (Chicago), and a lifelong resident of Newark. He conducted a general practice for 30 years and was a member of the staff of Beth Israel Hospital. He was also a member of the American Academy of General Practitioners.

DR. JOHN D. ROSSO

Dr. John D. Rosso of Princeton died in New York City on March 25 at the age of 47.

Dr. Rosso was a graduate of Long Island Medical College (1931) and served his internship at St. Francis Hospital, Trenton. He began practice in Princeton in 1946 and was school physician for St. Paul's School and for schools at Dutch Neck and Penns Neck. He was a member of the staff of Princeton Hospital.

DR. HENRY C. WOELFLE

Dr. Henry C. Woelfle died on April 1 in West Palm Beach, Florida at the age of 76.

Dr. Woelfle was graduated from Cornell University Medical School in 1902. He was a member of the surgical staff of the Jersey City Medical Center.

A former resident of Jersey City, since his retirement ten years ago Dr. Woelfle made his home in West Palm Beach.

Dr. Woelfle was an Emeritus Member of the Hudson County Medical Society and The Medical Society of New Jersey.

Announcements • • •

New Jersey Dermatological Society

At the annual dinner meeting of the New Jersey Dermatological Society held May 12, the following officers for 1954-55 were elected:

President: Emanuel Satulsky, M.D., Elizabeth; *Vice-President:* Harry Goldberg, M.D., Plainfield; *Secretary:* Seymour Hanfling, M.D., East Orange; *Treasurer:* Benjamin Burill, M.D., Montclair.

Convention Cruise

The North Carolina Academy of General Practice will hold a scientific assembly aboard the M. S. Stockholm October 16-22.

This convention cruise will feature a varied scientific program. Further information may be obtained from Mr. H. H. Allen, 550 Fifth Avenue, New York 36, N. Y.

Biological Photographic Meeting

The Biological Photographic Association will hold its annual convention at the Hotel

Chalfonte-Haddon Hall, Atlantic City, August 25-27. All interested physicians are invited to attend.

Dr. Schaaf Receives Award

Dr. Royal A. Schaaf, Past-President of The Medical Society of New Jersey, was chosen to receive the 1954 Alumni Meritorious Service Award from New York University.

Dr. Schaaf, cited for distinguished service to the University, received a scroll at the Alumni Federation's annual dinner on May 18. He will be presented with a bronze medallion at N.Y.U.'s commencement on June 19.

Medico-Legal Seminar

The Passaic County Medical Society and the Passaic County Bar Association announce a lecture to be given on June 23 at the Medical Society Headquarters, 625 Broadway, Paterson, at 8:15 p.m. Dr. Henry C. Crossfield will discuss the heart in industry.

All interested physicians are invited.

Distribution of Gamma Globulin

Distributing stations may release gamma globulin for administration to the contacts of cases of measles, German measles, infectious hepatitis, and poliomyelitis.

It is most urgent that every entry on the record card be completed before gamma globulin is released.

Gamma globulin is packaged as follows:

2 cc. and 10 cc. vials for use in measles, German measles, and infectious hepatitis. 10 cc. vials for use in poliomyelitis.

MEASLES

- (1) Non-immune household contacts of reported cases.
- (2) Non-immune children under 5 years of age, older chronically ill, recently ill, or debilitated children who have been intimately exposed to a reported case.
- (3) Non-immune hospitalized children exposed to a reported case.
- (4) Non-immune pregnant women who have been intimately exposed to a reported case.

Dosage: 2 cc. per individual, other than pregnant women.
10 cc. for pregnant women.

GERMAN MEASLES

- (1) Non-immune pregnant women who have been intimately exposed to a case.

Dosage: 10 cc. per individual.

INFECTIOUS HEPATITIS

- (1) Non-immune household contacts of reported cases.
- (2) Non-immune pregnant women who have been intimately exposed to a case.

Dosage: 2 cc. per individual, other than pregnant women.
10 cc. for pregnant women.

POLIOMYELITIS

- (1) Household contacts of a reported case.
- (2) Individuals who have been intimately exposed in another household to a reported case during the last four days of the incubation period, or the first week of illness.

Dosage: 10 cc. per individual.

Requests for withdrawal of gamma globulin for other purposes must be made directly to the State Department of Health, Trenton. (Phone: EXport 2-2131, Extension 8239).

County Society Reports • • •

Atlantic

A regular meeting of the *Medical Society of Atlantic County* was held at the Traymore Hotel, March 12, Dr. E. Harrison Nickman presiding.

The guest speaker was Dr. Charles A. Doan, Dean and Professor of Medicine, Ohio State University College of Medicine. His subject, "The Diagnosis and Treatment of the More Common Anemias," was an authoritative presentation.

The Insurance Committee presented a favorable report in reference to the Atlantic City Electric Company Group Hospital-Surgical Medical Plan.

The following applicants were elected to membership—regular: Drs. S. Stuart Mally and Gene N. Schraeder; associate: Dr. James C. Hitchner.

The society approved the report of the A.M.A. Committee for the Study of Relations between Osteopathy and Medicine, and directed its Welfare representatives to vote accordingly at the next meeting of the Welfare Committee of the state society.

A regular meeting of the *Medical Society of Atlantic County* was held at the Traymore Hotel, April 9, Dr. E. Harrison Nickman presiding.

The scientific portion of the program was in the form of a psychiatric panel. Dr. Thomas H. Ham, of Western Reserve School of Medicine, acted as moderator of a panel consisting of Drs. Amedeo A. Barbanti, Werner Hamburger and Samuel Dinenberg. Interesting psychosomatic and behavior problems were discussed in answer to submitted questions.

The following were elected to membership: associate: Drs. Donald C. Davidson and Paul H. Steel, residents at Atlantic City Hospital; courtesy: Dr. Frederick Frisch.

Dr. Nickman gave a brief interim report of a meeting of the State Welfare Committee, dealing with study of relations between osteopathy and medicine.

Dr. Weintrob, reporting for the entertainment committee, announced June 10 as the date of the outing.

Dr. Diskan reported, by request, on a Disabled Veterans meeting which he and Drs. Timberlake and Stamps had attended. The veteran's organization had requested a representative of the society to attend this meeting, in order, so their invitation stated, to clarify the stand taken by the A.M.A. in regard to medical care to veterans. Dr. Diskan's report was discussed by Dr. Allman, who stated that while no one denies the right of the disabled veteran to every possible consideration and care, extension of this service to every veteran for every non-service-connected disability, would impose an intolerable burden on the economic structure of the country. Further, he stated that a program of care such as demanded by veteran organi-

zations would result in a serious situation for civilian hospital facilities. It was apparent from this and other discussion that this was a problem with no easy solution, and one that would require extensive consideration at high levels.

Dr. Diskan further suggested innovation in the field of public relations, stating that he believed it was time for us to extend these relations beyond our own sphere. He accordingly moved that this society present an annual award to a citizen, outside its own group, who has done most to promote better understanding of the contributions made by the medical profession to the community. The selection will be made by the Executive Committee. This suggestion was approved by the society.

A letter from the Department of Public Relations of the A.M.A. was read which urged that county medical societies establish programs to provide the services of a physician to anyone unable to pay for medical care. As this was in line with a request from the Family Service Association of Atlantic City, it was ordered that the matter be referred to Dr. Whims and his committee for a further report.

LEONARD B. ERBER, M.D.
Reporter

Burlington

A regular meeting of the *Burlington County Medical Society* was called to order by Dr. Freeman W. Metzger, president, on February 11 at the Riverton Country Club.

The scientific portion of the meeting was devoted to a symposium on rheumatic heart disease, presented by members of our society: "Basic Pathology of Rheumatic Heart Disease," Dr. John Bauer; "Rheumatic Heart Disease in Children," Dr. George Wade; "Rheumatic Heart Disease in Adults," Dr. John Nicholson; "Surgical Treatment of Rheumatic Heart Disease," Dr. L. B. Reagan.

During a short business meeting that followed, Dr. John G. Rogers, Riverton, was elected to full membership; Dr. George T. Tracy, Beverly, was elected to emeritus membership.

The *Burlington County Medical Society* held its regular monthly meeting on March 11 at the Riverton Country Club with Dr. Freeman W. Metzger presiding.

Guest speaker was Dr. William Ramsey, Proctologist to the Pennsylvania Hospital, who discussed "Proctologic Diagnosis."

A regular meeting of the *Burlington County Medical Society* was called to order by Dr. F. W.

Metzer, president, at the Riverton Country Club on April 8.

The scientific session consisted of a home talent program as follows: "Rubella in Early Pregnancy," Dr. Edwin Foord; "Some Considerations in the Treatment of Allergies in General Practice," Dr. Paul R. Sparks; "Treatment of Arthritis in General Practice," Dr. R. Winfield Betts.

WILLIAM F. BETSCH, M.D.

Reporter

Camden

The regular monthly meeting of the *Camden County Medical Society* was held April 6, in the meeting rooms of the society. Dr. Edwin R. Ristine, president, presided.

Dr. John J. Litz was admitted to membership.

Dr. Robert A. Cooper introduced the guest speaker, Dr. Frank F. Allbritten, Associate Professor of Surgery, Jefferson Medical College. Dr. Allbritten spoke on the surgical treatment of mitral stenosis. His paper was discussed by Drs. Eynon, Halbeisen, Snape and Shipman.

Dr. Eynon presented a resolution from the Special Committee on the Medical-Surgical Plan of New Jersey. He likewise advised the society of the opinions expressed in the executive committee namely, that a committee be appointed to answer the resolution and express the feelings of the society. Dr. Eynon moved that the president appoint such a committee. Dr. Ristine appointed Dr. Sharp, chairman, Dr. James Eynon and Dr. Grimes, with the president, and secretary serving ex-officio.

Dr. Ornafe reported on the publicity for the forthcoming Public Health Forum and urged the members to participate and publicize it.

The Public Health Forum held on April 23, 24 and 25 was enthusiastically received by the residents of Camden County. The tireless efforts of the committee and the cooperation of the many participating physicians of Camden County achieved a boost for better public relations. A large number of free chest x-rays and urinalyses for sugar content were recorded. Eye-testing was likewise well received. The public watched interesting movies, browsed among twenty-five booth displays, and chatted freely with the doctors in attendance.

FREDERICK W. DURHAM, M.D.

Reporter

Cumberland

Under the chairmanship of Dr. Kurt M. Hansen, its president, the *Cumberland County Medical Society*, held its regular meeting on April 13 at the Richards Farm, Rainbow Lake, Bridgeton.

During the meeting the following officers were elected:

President: Dr. Frank J. T. Aitken, Bridgeton; *Vice-President:* Dr. Nicholas E. Marchione, Vineland; *Treasurer:* Dr. Samuel B. Pole, 3rd, Bridge-

ton; *Secretary:* Dr. Mary Bacon, Bridgeton; and *Reporter:* Dr. George F. Risi, Millville.

The society recommended that the Gloucester County Society be its guest at the first fall meeting in October.

A very interesting and informative lecture on disorders of menstruation was the high spot of the meeting. The speaker was Dr. Abraham E. Rakoff, Clinical Professor of Obstetric and Gynecologic Endocrinology, Jefferson Medical College.

GEORGE F. RISI, M.D.

Reporter

Essex

Dr. John L. Poole, associate attending surgeon of Memorial Hospital in New York was the speaker at the regular meeting of the *Essex County Medical Society* on April 8. His topic was etiologic and diagnostic problems of cancer of the lung.

Dr. Poole pointed out that pulmonary cancer has increased tremendously in incidence since 1900. He discussed the etiologic factors, including the controversial one of heavy cigarette smoking. Other possible causes are exposure to uranium, chromates and asbestos.

The need for early diagnosis was emphasized. On the average there is a ten month span between the appearance of symptoms and time of death in untreated cases. Diagnostic methods of value are biopsy via the bronchoscope, sputum, cytologic examinations and exploratory thoracotomy. Among those operated on for this disease only eight per cent of patients have a five year survival rate at the present time.

The last meeting of the 1953-54 year of the *Essex County Medical Society* was held at the Academy of Medicine on May 13.

Dr. William Hahn reviewed the achievements of the society during his administration. The work of the Chronic Ill Committee and its Home Maker Service were especially noted. This service, which allows invalids to have someone cook a meal and help with light housework, is greatly appreciated by patients and their families. It deserves the active support of all the members of the society.

Under the direction of Drs. Kenneth Gardner and Eugene Katzin, the Essex County Blood Bank has increased its activities. The new scheme of "blood credits" is bringing more donors, and is therefore making the bank even more active.

The new officers for the year 1954-55 were elected. They are:

President: Dr. Frank S. Forte; *President-Elect:* Dr. Jerome G. Kaufman; *First Vice-President:* Dr. Joseph A. Clarken; *Second Vice-President:* Dr. Edward A. Gullord; *Secretary:* Dr. Marcus H. Greifinger; *Treasurer:* Dr. Edward Steiner; and *Reporter:* Dr. Camille Mermoud.

Dr. Joseph Echikson, former president of the Essex County Medical Society, then presented the

past president's key to Dr. William Hahn and thanked him for the work that was done during the past year.

Following this, a meeting of the Essex County delegates to the state medical society convention was held, at which time the various issues to be brought up were discussed, and the delegates instructed.

CAMILLE MERMOD, M.D.

Reporter

Gloucester

The regular monthly meeting of the *Gloucester County Medical Society* was held at the Woodbury Country Club, February 18, with Dr. Ralph L. Moore presiding.

The scientific program was devoted to poliomyelitis, the speaker being the international authority, Dr. Lewis L. Coriell, Medical Director of the Camden Municipal Hospital. Dr. Coriell discussed the background of gamma globulin research, the development of the vaccine and the hopes held for it.

At the business session a letter was read from the New Jersey Pharmacy Board stating that after July 1, 1954, it would be illegal to use prescription blanks imprinted with the name of any pharmacy or pharmacist. The members voted yes to all five questions raised by the Medical-Surgical Plan committee concerning payment of assistants from Blue Shield funds.

The question of the recognition of osteopaths by our society was deferred to the March meeting.

With Dr. Ralph Moore in the chair, the regular monthly meeting of the *Gloucester County Medical Society* was held at the Woodbury Country Club, March 18. Dr. Baxter Livengood introduced the speaker for the scientific program, Dr. Perry S. MacNeal, Associate in Medicine at the Jefferson Medical College. Dr. MacNeal spoke on the management of the patient with headache, with special emphasis on migraine.

Dr. Paul H. Jernstrom of Woodbury and Dr. Richard DuPree of Paulsboro were elected to full membership in the society.

The admission of osteopaths to our society was disapproved at this time.

The regular monthly meeting of the *Gloucester County Medical Society* was held at the Woodbury Country Club, Woodbury, April 15, with Dr. Ralph Moore presiding.

Dr. Henry J. Tumen, Associate Professor of Gastroenterology at the Graduate School of Medicine, University of Pennsylvania, discussed the hepatitis problem during the scientific session.

A letter was read stating that a New Jersey Consultative Service for Convulsive Disorders was now available with Salem County Hospital being

the center for our area. The society approved the report of the committee concerning the payment of surgical assistants by Blue Shield.

LOUIS K. COLLINS, M.D.

Reporter

Hudson

Under the chairmanship of Dr. Joseph P. Donnelly, the *Hudson County Medical Society* held a regular monthly meeting at Murdoch Hall, Jersey City Medical Center, on February 2.

The society voted to continue its present emergency and night call program for another year.

Dr. Robert S. Hamilton, Hoboken, was elected to active membership.

Dr. George F. Lull, Secretary and General Manager of the American Medical Association was the guest speaker. He described the physical set-up of the parent organization and also some of the mechanical procedures employed by this "135,000-member, nine-million-dollar organization."

On March 2, *Hudson County Medical Society* held its regular monthly meeting at Murdoch Hall, Jersey City Medical Center, with Dr. J. P. Donnelly presiding.

Dr. Stanislaus J. Markarawicz, Bayonne, and Dr. Alfred Yager, North Bergen, were elected to active membership.

The guest scientific lecturer was Dr. Gene H. Stollerman, Medical Director of Irvington House for Children with Heart Disease, Irvington, N. Y.

HARRY T. ARONOWITZ, M.D.

Reporter

Middlesex

The regular monthly meeting of the *Middlesex County Medical Society* was held at the Roosevelt Hospital, Metuchen, on March 17 with the president, Dr. Malcolm M. Dunham, presiding.

Dr. Milton R. Bronstein of Fords was elected from associate to regular membership.

An interesting discussion of the maxillo triad and its correction was presented by Dr. Irving B. Goldman, Consulting Otolaryngologist to the Beekman Downtown Hospital, New York.

A request was made that all members who desire to speak before lay groups clear with the Speakers Bureau of the county medical society beforehand.

Dr. Malcolm M. Dunham presided at the regular monthly meeting of the *Middlesex County Medical Society* which was held at the Roosevelt Hospital, Metuchen, on April 21.

Dr. Charles H. Calvin introduced the guest speaker, Dr. Robert F. Dickey, Senior Attendant,

Department of Dermatology, George F. Geisinger Memorial Hospital, The Foss Clinic, Danville, Pa. Dr. Dickey gave a very enlightening talk on the dermatologic manifestations of internal diseases.

A motion disapproving a state medical society convention cruise to Bermuda in May, 1955 was passed.

IVAN B. SMITH, M.D.
Reporter

Monmouth

The fourth annual joint dinner meeting of the *Monmouth County Medical Society*, the Monmouth County Dental Society and the Monmouth-Ocean County Pharmaceutical Society was held on March 31 at Joseph's Restaurant, West Long Branch.

Among the guests were the following: the presidents of the three societies; Senator Richard Stout; Col. Otto Churney, Post Surgeon of Fort Monmouth; Dr. Taylor, President of Ocean County Medical Society; Dr. John L. Voight, Chief of Pharmaceutical Extension Service of Rutgers University; Mr. Wilbur E. Powers, Secretary of State Board of Pharmacy; Mr. John Debus, Secretary to the State Pharmaceutical Association; and Dr. James W. Parker, Sr., a Trustee of Howard University and member of the State Board of Education.

Entertainment was provided by the Fort Monmouth Variety Show featuring Frank Bionco as vocalist.

DONALD W. BOWNE, M.D.
Reporter

Morris

The *Morris County Medical Society* held its regular meeting on April 15. President Jack L. Voss chaired the meeting at the Warner Chilcott auditorium.

The executive committee reported on the physician's role in the projected polio vaccine test this spring.

Dr. Herbert Chassis, Associate Professor of Medicine at New York University College of Medicine, was the speaker of the evening. Dr. Chassis addressed the society on the treatment of hypertension.

ALBERT ABRAHAM, M.D.
Reporter

Ocean

The annual dinner dance of the *Ocean County Medical Society* was held at Winding River Inn on March 15. Among the guests were Dr. Henry B. Decker, president of the state medical society, Richard I. Nevin, executive officer, and Mrs. Frank S. Forte, president of the state woman's auxiliary.

The following officers were elected: *President*—Dr. Richard Gove; *Vice-President*—Dr. Frank

Brown; *Treasurer*—Dr. Jesse Schulman; *Secretary*—Dr. Joseph Camarda; *Reporter and Historian*—Dr. Abraham Goldstein.

ABRAHAM GOLDSTEIN, M.D.
Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held on December 15, 1953, at the Medical Society Building. Dr. Floyd Fortuin, the president, presided.

The following physicians were elected to active membership: Joseph A. Adamcik, Passaic; Joseph J. Bono, Allwood; George M. Meier, Butler; Vincenzo R. Onorato, Pompton Lakes; Wilford J. Ratzan, David Roth, Frank Scillieri, Ralph J. Veenema and Ruth Wong, all of Paterson. Dr. Leonard Marmor, Passaic, was elected to associate membership.

Dr. Peters of the Program Committee introduced John K. Lattimer, M.D., who discussed the modern treatment of kidney tuberculosis.

The regular monthly meeting was held on January 19 at the Medical Society Building. Dr. Floyd Fortuin presided.

Dr. Aaron Schwinger, East Paterson, was elected to active membership. Dr. Howard J. Isenberg, Passaic, was elected to associate membership.

It was voted that the society set up a committee to study the costs and feasibility of establishing a medical society telephone answering service.

Dr. Bernard D. Pinck introduced Mark M. Ravitch, M.D., who spoke on surgery of tumors and deformities of the chest wall in infants and children.

The regular monthly meeting was held on February 16 at the Medical Society Building. Dr. David B. Levine presided in the absence of the president.

Physicians elected to active membership were: Frederick S. Barnes, Passaic; Carol R. McCune, Pompton Plains; Ernest C. Lydecker and Louis Serafini, Paterson.

Dr. Henry D. Janowitz introduced Dr. B. Burrill Crohn, a pioneer in the study of ulcer and recipient of the Friedenwald Medal in 1953. Dr. Crohn spoke on gastro-intestinal hemorrhage.

The regular monthly meeting was held on March 16 at the Medical Society Building with Dr. Fortuin presiding.

Without dissent it was voted to initiate a new procedure, recommended by the Welfare Council, in electing candidates for membership at the regular meetings. Hereafter, except where one or more members call for an individual secret ballot, the names and endorsers of candidates are to be read and upon motion from the floor, the secretary will

be instructed to cast a single ballot for admission of the applicants.

Drs. Robert T. Dunn, Preakness, and John Sarokhan, Paterson, were then elected to associate membership.

The Special Committee on Relations Between Osteopaths and Medical Doctors submitted a report to the society advocating the establishment of a basis for ethical professional relationships between M.D.'s and osteopaths. This report was approved by the society.

Dr. Fortuin introduced Dr. Harold G. Wolff, Professor of Medicine (Neurology) at Cornell University Medical College, who spoke on headache mechanisms.

The regular monthly meeting of the *Passaic County Medical Society* was held on April 20, at the Medical Society Building. Dr. Fortuin, the president, presided.

Dr. Christopher T. Reilly, Ridgewood, was elected to active membership and Dr. Robert H. Joelson, to associate membership.

Dr. Jehl, the secretary, announced the death of Dr. Louis Cohen of Passaic, expressing the deep regret of the society at the loss of this colleague.

The proposal for the annual meeting in 1955 to take place on shipboard was approved.

After discussion, the resolution offered by the state society's Special Committee on Division of Surgical Fees by the Medical-Surgical Plan was approved, with the exception of Point 4, which was amended.

Dr. Irving Okin, chairman of the Committee on Pharmaceutical Problems, then reported on joint meetings of his committee with the Pharmaceutical Association's Committee on Professional Relations and the Welfare Council. He described the feelings of the pharmacists who felt that they are not getting proper cooperation from physicians on a number of professional matters, and asked society members to: 1) be sure to give written prescriptions for narcotics; 2) give written instructions as to the number of times the prescription may be refilled, or leave word with the druggist; 3) take the label from samples containing narcotics if these are given to patients, to prevent unauthorized refilling; and 4) support the county society's request to the state society for action on the paregoric law, which presently requires a written prescription for paregoric. Dr. Okin also reported that the Pharmaceutical Association was no longer able to supply free prescription blanks, but would do so at \$1.75 per thousand for those physicians who wished them. Dr. Okin's report was accepted unanimously.

Dr. Fortuin then introduced Dr. Louis M. Rousselot, Professor of Clinical Surgery, New York University College of Medicine. Dr. Rousselot's topic

was, "Present Status of Surgical Therapy in Portal Hypertension, with Particular Reference to Application of Portal Venography."

DAVID B. LEVINE, M.D.
Reporter

Union

A regular monthly meeting of the *Union County Medical Society* was held at the White Laboratories in Kenilworth on March 10. During the business session, with Dr. William H. McCallion, president, presiding, there was a detailed discussion concerning the purchase of permanent headquarters for the society. It was finally decided to refer the question to the membership at large by mailed questionnaires.

The following four candidates were admitted to membership in the society: Drs. Jean H. Abel Cramer, and Stasys Petrauskas, Elizabeth; Dr. Robert C. Specht, Summit, and Dr. Harrison Fertig, Plainfield.

The scientific session was devoted to a symposium concerning the control and treatment of alcoholism. William J. Harris, Jr., Chairman, Bureau of Alcoholism Control, New Jersey State Department of Health, and Dr. C. Nelson Davis, Medical Director of the Malvern Institute and Chairman of the Committee on Alcohol Studies of the Philadelphia County Medical Society, opened the discussion and then conducted a question and answer period.

MERTON L. GRISWOLD, JR., M.D.
Reporter

New Jersey Proctologic Society

The New Jersey Proctologic Society held its annual dinner meeting at the Military Park Hotel in Newark on April 13. The guest speaker was Dr. Stuart T. Ross, secretary of the American Proctologic Society. His subject was fistula-in-ano, and he presented an enlightening discussion, stressing the anatomic basis of its surgical treatment.

Officers elected for the ensuing year are: *President*—Dr. Saul Zager, Newark and East Orange; *Vice-President*—Dr. Richard Hopping, East Orange; *Secretary*—Dr. Norman V. Myers, Tenafly; *Treasurer*—Dr. Irving G. Larkey, Newark and Passaic.

Any New Jersey physician who has an interest in proctology and wishes to obtain information on joining the society may do so by writing to the Secretary at 136 Engle St., Tenafly.

NORMAN V. MYERS, M.D.
Reporter

Woman's Auxiliary • • •

Mrs. Paul E. Rauschenbach, President, 1954-1955

Mrs. Paul E. Rauschenbach of Paterson, was installed as President of the Woman's Auxiliary to The Medical Society of New Jersey on May 18 in Atlantic City.

Mrs. Rauschenbach has a long record of service to the woman's auxiliary of her county medical society and to the state auxiliary. On the state level she served as public relations chairman from 1949 to 1951; as civil defense chairman, 1951-1952; chairman of the program committee, 1952-1953; and as chairman of the fall conference, 1953-1954. She was president of the Woman's Auxiliary to the Passaic County Medical Society in 1952 to 1954 and served this society as public relations chairman from 1946 to 1950. She also was program chairman of the county medical society auxiliary from 1950 to 1952.

Besides her auxiliary activities Mrs. Rauschenbach has been an indefatigable worker in many public service organizations. She has served on the governing and executive boards of the council for local public health services of New Jersey, New Jersey Health and Sanitary Association, the Consultant Committee on Homemakers Service of the Division of Chronic Illness Control of the State Department of Health. She has also been on the board of the Greystone Park Association, the Family Service of Paterson and Vicinity, the Passaic County Health Council (school health committee) and the Paterson Council of Social Agencies. She has been chairman of the Welfare Department of the Paterson Woman's Club.

Mrs. Rauschenbach is an active member of



St. Paul's Episcopal Church in Paterson, where her husband, Dr. Paul E. Rauschenbach, is attending obstetrician on the staff of the Paterson General Hospital. She has four children: Karen Ross, Peter Bishop, Henri Simons and Carl Ryan.

The Medical Society of New Jersey is proud to welcome such an active member and loyal supporter as president of its Woman's Auxiliary for the coming year.

AUXILIARY REPORTS • •

Essex

The *Woman's Auxiliary to the Essex County Medical Society* held a regular monthly meeting on February 24 with Mrs. Stuart Z. Hawkes, President, presiding.

The Auxiliary approved the following donations: \$1,000 to the Essex County Service for the Chronically Ill; \$25 to the American Cancer Society; \$25 to the American Red Cross. It also approved the transfer of \$1932 from the general fund to the

benevolent fund, this sum to be used for nurse scholarships.

Seven new members were welcomed into the Auxiliary.

Following the meeting a bridge party was held for the American Medical Education Foundation, from which \$175.05 was realized.

A most interesting talk on the natural superiority of women was given by Dr. M. F. Ashley Montagu after the completion of business at the combined

executive board and regular monthly meeting of the *Woman's Auxiliary to the Essex County Medical Society* held at the Woman's Club of Orange on March 22. Presiding was the president, Mrs. Stuart Z. Hawkes.

The honoring of nine past-presidents was conducted by Mrs. Jesse Glazier at our March 22 meeting. She presented each with a beautiful floral corsage. At this meeting Mrs. Harry G. Wortman, Jr. of Nutley was welcomed as a new member.

Auxiliary members again contributed their time selling flowers and potted plants for the Easter Seal Drive. Mrs. Frank Bellucci, Booth Chairman and Mrs. Anthony D'Addario, Co-chairman, worked in conjunction with the New Jersey Society for Crippled Children in covering the booths during March 15 through March 20. The booths were located on the main floor of L. Bamberger & Co. in Newark.

The names of the two recipients of our annual Nurse Scholarship Award were announced by Mrs. John Torppey: Anne Leese, East Orange, Orange

Memorial Hospital and Jane Volle, Newark, East Orange General Hospital.

MRS. HARRY E. DIGIACOMO
Chairman, Press and Publicity

Monmouth County

A millinery fashion show dramatizing safety was presented at the February 28 meeting of the *Woman's Auxiliary to the Monmouth County Medical Society*, held at Shadowbrook Inn, Shrewsbury. Mrs. Otto Lehman, Long Branch, presided.

At the business meeting, the nominating committee presented the following slate of officers: *president*, Mrs. John Ayers, Jr.; *president-elect*, Mrs. Donald Bowne; *vice-president*, Mrs. John Tilley; *secretary*, Mrs. J. P. Cooper, 3rd and *treasurer*, Mrs. Vincent DeRosa.

MRS. HARRY D. FEINBERG
Chairman, Press and Publicity

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Country Doctor. Cornelius Wilson Larison, of Ringoes, Hunterdon County, New Jersey, 1837-1910. By Harry B. Weiss, Sc.D. 235 p. Trenton, New Jersey Agricultural Society, 1953. (\$2.50)

The remarkable character described in this volume is in the direct line of many American doctors who have made contributions to the cultural progress of our country. Although born in a small, provincial community, without the advantages of adequate educational facilities, as a boy he literally forced himself, despite parental objections, to acquire the training he so avidly desired. His experiences as local schoolmaster in handling unruly farm boys would make good reading for some tender pedagogues and parents of our day. After graduating from Geneva Medical College in 1863 he returned to his home community and started a practice which continued until his death in 1910. The medical precepts of Dr. Larison were much in keeping with those of his time. He believed in prenatal impressions, opposed vaccination, and held so low an opinion of his colleagues that he refused to be treated by them during two serious illnesses. On the other hand, he held advanced views in favor of vivisection at a time when this was violently opposed by the pillars of the community and his views on fresh air and proper diet have quite a modern tone.

However, it is not as a physician that Dr. Lari-

son takes a position of eminence. This man was a natural teacher, philosopher and scientist. We soon find him establishing courses for other physicians in the neighborhood, giving lectures in natural science at the University of Lewisburg and establishing at Ringoes a seminary and academy of science and art. His dynamic personality attracted devoted assistants who encouraged him in his multitudinous interests. Undoubtedly, his most imposing claim to fame lies in a firm advocacy of a reform in spelling, a subject which had attracted him from childhood and to which he devoted his greatest energies in the later years of his life. His really important contribution in this field is evidenced by numerous publications and by the establishment of "The Journal of American Orthoepey" which became an important vehicle for the propagation of simplified spelling and brought Dr. Larison into communication with many scholars of America and England. These latter not only contributed articles but praised and encouraged the doctor in his work. This indefatigable worker also found time to publish a periodical on health, numerous articles on local history and contributions to the improvement of agriculture.

Surprising as it may appear, the tremendous activity of Dr. Larison is not an isolated phenomenon. In a thesis written several years ago the present reviewer found many instances of noteworthy participation by earlier American physicians in the intellectual ferment of their day. Many were out-

standing leaders in education, various reform movements, political progress and social betterment, as well as in applied science. We owe, therefore, a real debt of gratitude to Dr. Weiss for focusing our attention on the colorful figure of Dr. Larison who may well act as an inspiration for the doctor of today to resume his neglected place of leadership in the cultural life of the community.

MORRIS H. SAFFRON, M.D.

Doctor—It Tickles! By Henry Felsen. Pp. 120, New York, Prentice-Hall, Inc. 1953. (\$2.95)

Broad slapstick satire is applied to the medical profession by Mr. Felsen in this small volume. The opening chapter describes in hilarious terms the admission of a hospital patient for a routine physical check-up. From the time the patient leaves his apartment in a stretcher too large for the narrow hallway until he pays his final bill his travails are depicted in a humorous (if not quite truthful) style.

The tone of the book thus having been set, the author then takes sweeping blows at obstetricians, psychiatrists, hypochondriacs, TV superspecialists, and, last but not least, surgeons.

If you suffer grandeurs of delusion about yourself as a physician, this short, sweet and funny book will soon reduce you, in gales of laughter, to proper size.

R. D. GOODMAN, M.D.

An Approach to General Practice. By R. J. Pinsent, M.D. Pp. 166. Baltimore, Williams and Wilkins Company, 1954. (\$3.50)

The essential similarity and the interesting differences between British and American private practice are highlighted by this shrewd volume. The author is a Britisher delivering to his fellow GPs a warehouse full of tips about how to be happy under the National Health Act. It is necessary to devote an entire chapter to explaining the 39 forms that are part of every private practitioner's daily life in modern England. The book is innocent of propaganda for or against the British system. Dr. Pinsent takes it as he finds it, assuming that the welfare state and the practice of medicine by "form" are here to stay. He makes many wise and practical observations about the opening and maintenance of a private office: a "surgery" as our British brethren call it. He discusses the differences between handling old patients and handling young ones. He reviews problems in diagnosis and treatment that are peculiar to private practice and general practice. He has interesting observations about the mind of the patient and the mind of the

doctor. He makes some inspiring comments on the research possibilities of private practice.

The reader must be careful to keep in mind the difference between British and American terms. Thus, the theatre sister is not a chorus girl; she's the operating room nurse. Even the word "hospital" has a different connotation in England. Our ordinary community hospitals here would be "nursing homes" in Britain. The chief nurse would be the matron. There is, apparently, a vast gulf between practice in a hospital and practice in a private office; it seems as if no British M.D. does both. He is either a narrowly specialized hospital staffer; or a broad-gauged, quite unspecialized "surgery" (meaning "private office") doctor.

The book provides hours of interesting reading. It can be kept on a night table and dipped into a chapter at a time. It is graceful and gracious reading too: wise, witty and provocative.

VICTOR HUBERMAN, M.D.

Electronics for Physiological Workers. By I. C. Whitfield, Ph.D., Lecturer in Physiology, University of Birmingham, Pp. 236. New York, St. Martin's Press, 1953. (\$3.50)

This small volume, compact, accurate and factual, contains material which will be of considerable interest to physiologists. The author states in his preface that "this is not a book for those who hope, in an idle hour, to pick up something about electronics," and the text bears out this statement.

In recent years physiologists have come to rely more and more upon electronic amplifiers in various forms. The biologist who has sought advice about methods of amplifying and recording tissue and cell potentials will find here concise explanations of many important circuit and tube properties. Terms like time-constant, impedance, feedback, and phase shift are all explained adequately. Mathematics is minimal and elementary. The book is meaty and much material is crammed into its pages.

Omissions are apparently a matter of scope. The cathode ray tube is described in detail but other recording devices such as mirror galvanometers or direct-writing galvanometers are barely mentioned. Nor does the author describe transducer elements. There is no mention of sound amplifiers such as cardiologists use for recording heart sounds.

One important omission is the carrier amplifier, a circuit now being used in many instruments for recording intracardiac and intravascular pressure pulses.

The book contains many explanatory diagrams, averaging more than one to a page. The type is easy to read and the author writes in a clear, simple style.

DAVID BIBER, M.D.

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No. 6

A Comparative Analysis of the Post-Discharge Experiences of Tuberculous Patients

By Sol L. Warren, Ph.D., *The American Review of Tuberculosis*, February, 1954.

Vocational rehabilitation, as an organized program of public aid to the physically handicapped, had its inception in this country some thirty-odd years ago. There is general acceptance of the program, yet its definitive values remain essentially unconfirmed. The recognition of the need for systematic research in this field prompted the evaluative study described in the present report.

The objectives of the study were: to discover whether differences could be discerned between a group of persons who participated in a vocational rehabilitation program and a comparable group who did not participate in such a program; to determine, if any such differences were found, their nature, extent, and significance to the individual, the rehabilitation agency, and the community.

The most important characteristic of the study was its method of approach in setting up controlled conditions. Scrupulous attention was given to the three primary demands of scientific analysis in causal-comparative research. These include: verification of the comparability of experimental and control groups prior to the introduction of the experimental variable; maintenance of uniform conditions during the experiment; and the demonstration by valid statistical techniques of the significant differences between the groups.

Two hundred and fifty-seven patients discharged from Municipal Sanatorium of New York City at Otisville, New York during 1942 and 1943 were selected because they met the follow-

ing criteria: they were first admissions to the hospital who had been discharged with medical consent as having arrested tuberculosis; they were all on four-hour activity tolerance, had favorable prognoses, and needed rehabilitation assistance; they were of equivalent economic status; they had been processed through the sanatorium rehabilitation program.

Following discharge, these patients separated into two groups, as some availed themselves of the services provided by the state agency whereas others did not. On the fifth anniversary of discharge from the sanatorium, both groups were interviewed. Additional data were obtained from clinics, hospitals, physicians, social agencies, friends, relatives and employers. Of the 257 patients selected for the study, 240 were located and included. The remaining 17 could not be found or refused to cooperate. Of the 240 subjects studied, 79 participated in the state agency's program while 161 failed to take part.

The opposing groups were compared with respect to their pre- and post-discharge characteristics and experiences. Criteria of comparison included factors commonly associated with physical, emotional, social, economic, and vocational adjustment.

A pre-discharge comparison of the participating and non-participating groups disclosed their equivalence with respect to every criterion measured. Among these were such factors as age, sex, color, religion, place of birth, and citizenship status. Socio-economic factors such as marital status, number of dependents, source of income, public welfare experience, and contacts with social agen-

cies, the highest school grade completed, in-sanatorium activities, psychological test results and personality characteristics were also equated. Under physical data, the comparison covered family and personal tuberculosis history, the clinical status, activity tolerance, and prognosis. Included among the vocation factors were length of work history and number of occupations and jobs held. A detailed comparison was made of the last pre-sanatorium job.

On the basis of the pre-discharge analysis, it was concluded that, at the point of discharge from the sanatorium, the participating and nonparticipating groups were comparable in every meaningful respect. This equivalence provides a valid basis for conclusions bearing on the post-discharge experiences of the groups.

The post-discharge analysis compared the groups with respect to all pertinent factors mentioned above plus many others. The findings disclosed more favorable outcomes for the participating group in virtually every aspect investigated. Only the more significant ones are summarized here.

The participants exhibited considerably lower mortality and relapse rates than the non-participants. Although of comparable physical status at the time of discharge, at follow-up examination those who had received rehabilitation assistance were uniformly better off than their non-participating counterparts. Although both groups earned approximately the same wages in their last pre-sanatorium jobs, the participants entered initial post-discharge jobs at decidedly lower wages than did the non-participants. When wages were recorded at the end of the five-year period, the participants had forged ahead quite conclusively.

Without presenting details, it is recorded here that the jobs held by the participants were almost invariably better than those held by the non-participants. Such items as days and hours of work, total earnings, number of wage increases and promotions, job tenure, sick-leave provisions, employer awareness of the tuberculous background, and absenteeism were considered.

On the basis of the findings disclosed by the

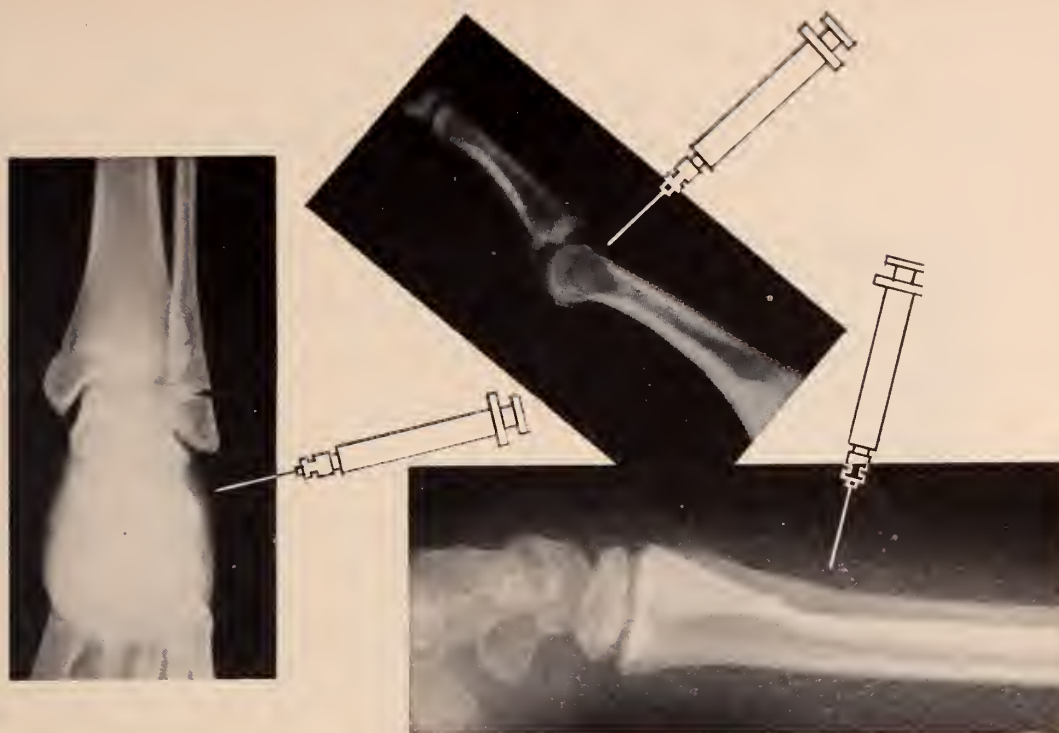
present study, it may be concluded that participation in the vocational rehabilitation program produced consequences which were definitely significant to the persons who participated, to the rehabilitation agency which provided the services, and to the community as a whole.

In terms of individual experiences, participation in the program produced certain specific outcomes. In encouraging adequate convalescence and attention to medical advice, in discouraging premature resumption of employment, and in promoting suitable vocational objectives, it contributed significantly to the attainment and maintenance of normal health. In helping by supportive and tangible assistance to overcome the psychologic trauma associated with tuberculosis it contributed to the restoration of normal life patterns. In furnishing sound occupational guidance, adequate job preparation, placement assistance, and close supervision of employment, it contributed to satisfactory vocational experience in occupations commensurate with mental levels, interests, aptitudes, education, work background and physical capacities. By providing useful skills in remunerative fields it contributed to the restoration of financial independence. In creating an advantageous physical, emotional, vocation, and economic climate, it contributed to the assumption of the community and family obligations which are essential to social and personal adjustment.

The findings substantiate the economic soundness of the rehabilitation program and provide the basis for future development and expansion.

Finally, in terms of community involvement, the findings are significant because they provide facts which should enlighten the public and management regarding the proficiency, stability, and vitality of ex-tuberculous workers properly placed. They demonstrate the practical and tangible benefits to the community in terms of tax returns and purchasing power and in savings in welfare and hospitalization costs. They point the way to a happier citizenry through the promotion of economic self-sufficiency, physical and emotional well-being, social and vocational adjustment, and general personal contentment.

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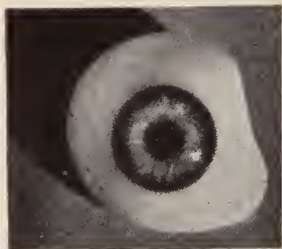
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1. MacAusland, W. R., Jr.; Gartland, J. J., and Hallock, H.: The Use of Hyaluronidase in Orthopaedic Surgery, *J. Bone & Joint Surg.* 35-A:604 (July) 1953.

2. Swenson, S. A., Jr.: Minor Surgical Aspects of Closed Wounds, *Am. J. Surg.* 87:384 (March) 1954.

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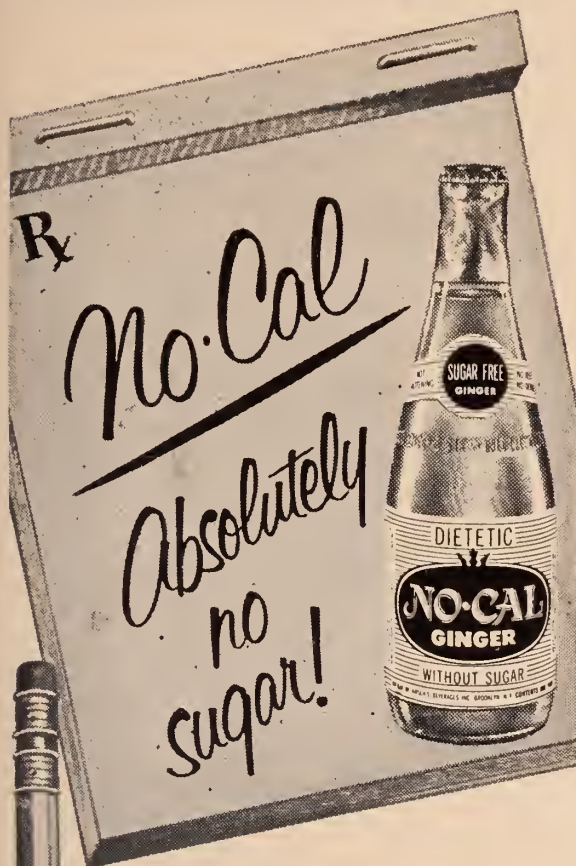
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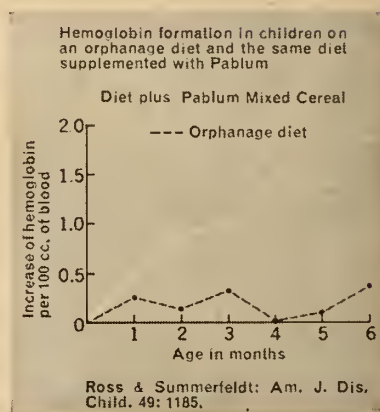
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1. Smith, N. J., and Rosello, S.: J. Clin. Nutrition 1: 275, 1953;
2. Jeans, P. C., in A.M.A. Handbook of Nutrition, ed. 2, New York, Blakiston, 1951, p. 280.

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OF

THE MEDICAL SOCIETY OF NEW JERSEY

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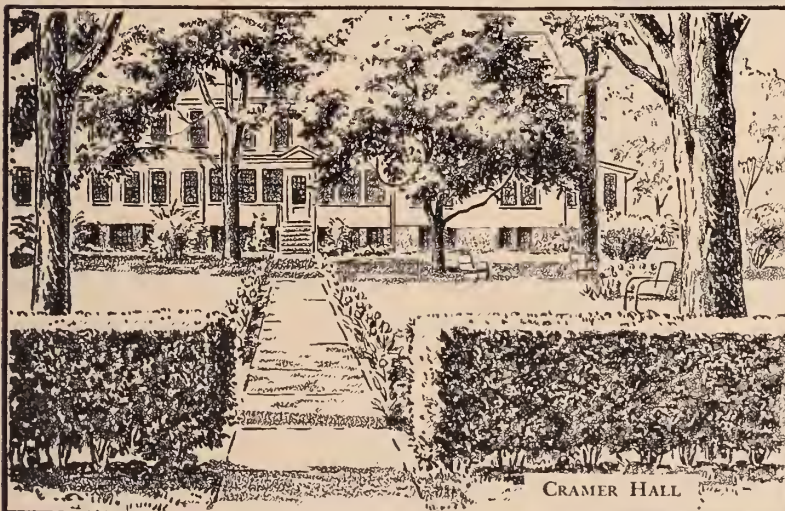
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*Kirsner, J. B.; Brandt, M. B., and Sheffner, A. L.: Diet and Amino Acid Utilization in Gastrointestinal Disorders, *J. Am. Dietet. A.* 29:1103 (Nov.) 1953.

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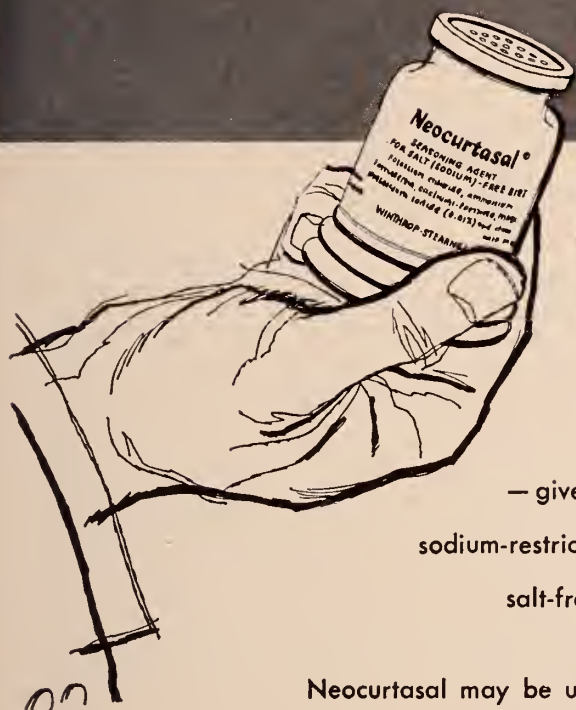


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1. Heller, E. M.: The Treatment of Essential
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Jour.*, 61:293, Sept., 1949.

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*Heck, W.E.; Lynch, W.J., and Graves, H.L.: *Acta oto-laryng.* 43:416, 1953.

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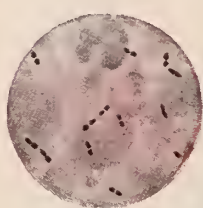
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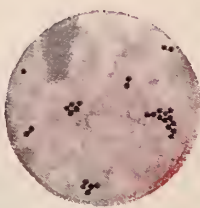
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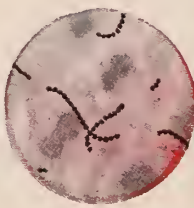
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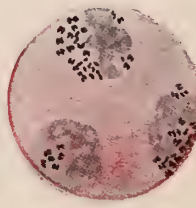
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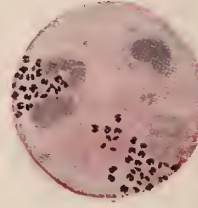
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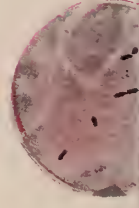
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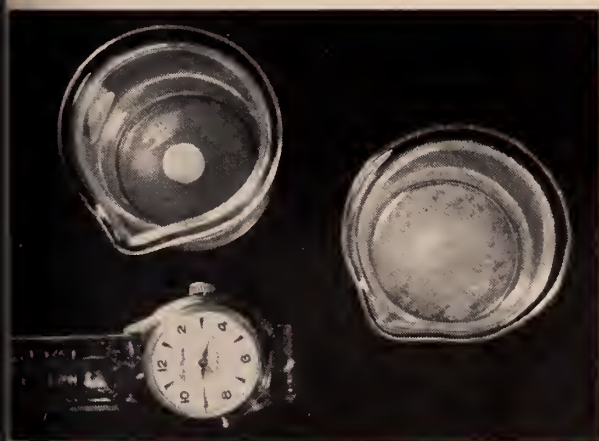
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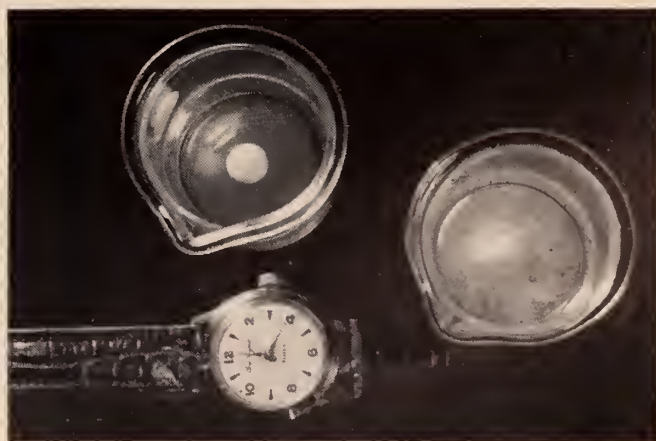
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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Harrison S. Martland, 1883-1954

Very few New Jersey physicians can honestly be called "internationally known." Perhaps the small size of our state—or its lack of a medical school—or its existence in the shadow of two metropolitan giants across its border rivers—perhaps these are responsible for the fact that even the best New Jersey physician seldom extends his fame beyond the middle Atlantic area.

Harrison S. Martland was one of the few exceptions. Of him it can be truly said that he was known throughout the globe. To put it quite simply: Harrison S. Martland was a world-famous pathologist. He was certainly New Jersey medicine's proudest ornament.

He was an original thinker. Not just a hard-working pathologist, but a fresh and original thinker. His development of the concept of "punch drunk" alone would have earned him a place in medicine's hall of fame. His most glamorous honor was his pioneer work in radio-

activity. In the pre-atomic age, he saw the dangers of atomic radiation. The Atomic Energy Commission repeatedly acknowledged his pace-making work in atomic safety. Indeed the permanent safety exhibit now at Oak Ridge is the creation of our fellow Jerseyite, Harrison Martland. He did original work on bullet wounds. He was, more than any other man, responsible for the concept of the medical examiner's office in New Jersey as a replacement for the creaking coroner system. He was the first non-New-Yorker to become president of the New York Pathological Society: and as any New Yorker will confess, that was no mean accolade. His work as a crime-detector attracted nationwide attention. In the field of scientific crime detection he was a latter day Sherlock Holmes.

New Jersey must have had a special place in his heart. Perhaps because he was born here; more likely because here his heart was—

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his family, his confreres, and the inner circle of his army of friends. With his reputation, he was constantly receiving glamorous offers to go elsewhere. He could have been a professor. He could have gone to any state in the union and developed a fabulously prosperous private practice. It is no secret that New York City tried repeatedly to get him to serve as their Chief Medical Examiner, and always he turned down the world's number one city, for the post in Essex County, New Jersey. He could have written his own ticket anywhere. But here he stayed.

He was honored in life and he will continue to be honored. He was a laureate of the Edward J. Ill Award. He was President of the Academy of Medicine of Northern New Jersey. He was President of the Essex County Medical Society. He was the eponym of a

now famous lectureship at the Essex County Anatomical and Pathological Society: and the eponym of the largest hospital in our state's largest city.

He was a well-rounded medical scholar who combined a wholesome respect for theoretical foundations with an extraordinary practical skill. He was—but it seems unnecessary to keep piling on honor and honor. Such a listing might make him sound like a stuffed shirt. And that he never was. He detested pomposity, "side," exhibitionism, pretense.

And he was a man! Robust in body, robust in mind, robust in sense of humor, Harrison Martland was, above all, a whole man.

He was the brightest star in New Jersey's current medical galaxy. And with his passing a star has, indeed, fallen.

Control of Leukemia

Leukemia is increasing in incidence. The crude mortality rate from leukemia in the United States showed a sharp increase from 1922 through 1944. Although this may be due partly to improved diagnostic methods, a continued increase from 1939 to 1944 indicates that there is an actual, as well as an apparent, rise in the frequency of this disease. Each year since 1940 more than 5,000 persons in the United States have died of leukemia and in the past few years the deaths have risen to more than 6,000.

William Dameshek¹ speaking at the annual meeting of the Massachusetts Medical Society on May 20, 1953, has reviewed the present status of leukemia. Leukemia is a form of generalized white cell system proliferation. The white cells arise from four different sources: bone marrow, lymphoid system, reticulo-endothelial system and the system of plasma cells (plasmocytes). Each one of these "systems" is diffusely scattered throughout the body and

each produces leukocytes, some of which may be found in the peripheral blood. The bone marrow produces polymorphonuclear leukocytes; the lymphoid system lymphocytes; the R-E system monocytes and the plasma cells system plasma cells or plasmocytes. Each white cell system is subject to proliferative activity. This is usually benign and reversible and in response to a well defined stimulus, particularly infection. However, trauma, hemorrhage, stress and "toxic" causes also may result in a benign increase in white cells, which disappears when the cause is removed.

In general there are two types of malignant leukocytic proliferations—one which is generalized and the other localized. The generalized type is known as leukemia. According to present concepts leukemia is a generalized neoplastic proliferation of one of the white cell systems. The generalized proliferations of each of these systems may be classified as leukemias—granulocytic, lymphocytic, monocytic, according to the cell type seen in the blood, and plasmocytic leukemia or multiple myeloma. The localized form of proliferation is the granulo-

1. Dameshek, W.: The Outlook for the Eventual Control of Leukemia. *New Eng. J. Med.* 250:131, January 28, 1954.

sarcoma (chloroma), lymphosarcoma, reticulum-cell sarcoma, Hodgkin's disease, eosinophilic granuloma and plasmocytoma (solitary myeloma), respectively. Dameshek calls these localized proliferations "leukosarcoma."

The etiology of leukemia remains a mystery. The only well known cause is that due to irradiation with x-rays. In radiologists, the incidence of leukemia is approximately eight times that in a comparable group of physicians in other specialties. Frequent and prolonged x-ray exposure with laxity in protection almost certainly favors leukemia. A single high dosage exposure of x-rays and gamma radiation may also produce leukemia, as shown by the studies following the atom bomb explosions in Hiroshima and Nagasaki.

Several causes for leukemia have been suggested. Among those which deserve the most serious consideration are chemicals such as benzene or carcinogenic hydrocarbons. The possibility that over the years humans are toxically exposed to these chemicals or their derivatives is suggested as an explanation for the increased incidence of leukemia.

Another possibility, which has been well documented by the work of Gross, is that leukemia is a virus infection. However Gross' work has been restricted to mice and the transfer of this theory to humans still requires confirmation.

Other theories of the etiology of leukemia involve hormones and heredity. It has also been suggested that leukemia is due to a disturbance of leukocytic elimination and, less plausibly, that it is a deficiency disease similar to pernicious anemia.

In spite of the lack of knowledge concerning the etiology of this disease there have been striking advances in therapy. For the acute leukemias Aminopterin® has proved to be of distinct value. It has definitely prolonged the life of children with acute leukemia although eventually relapses occur. Unfortunately, with each successive retreatment remissions become more difficult to attain and the patient finally succumbs.

ACTH or cortisone appear to enhance the effect of Aminopterin® and to reduce the

"toxic" reaction to this drug. They also decrease the bleeding tendency which is common in acute leukemia, particularly when Aminopterin® is used, and have a myelostimulatory effect so that the aplastic bone marrows induced by Aminopterin® are avoided.

Unfortunately, remissions with ACTH and Aminopterin® are short lived and relapse is difficult to treat. Eventually in every case it is no longer possible to reverse the pathologic process and death inevitably results.

Triethylene melamine (TEM) has been most effective in the treatment of chronic leukemias and leukosarcomas. It is valuable in many cases of Hodgkin's disease, chronic lymphocytic leukemia, chronic granulocytic leukemia and lymphosarcoma. It must be given with great caution and it should never be given in doses greater than 2.5 mg. A test dose is worthwhile, because an occasional patient shows severe reactions, both generalized and hematologic. In the first course the dose should be no larger than 2.5 mg. given three times in the first week and twice in the second. The drug is always administered an hour before breakfast.

TEM is most valuable in chronic lymphocytic leukemia and lymphosarcoma. A complete clinical hematologic and bone marrow remission may occur in about six out of ten cases of chronic lymphocytic leukemia. TEM, 2.5 mg. every ten to fifteen days, may maintain the remission for long periods.

Chronic granulocytic leukemia is best treated with x-ray therapy over the spleen and with urethane for maintenance. However a new drug GT41 (myleran) may be more effective than either of these.

Although the prognosis for leukemia still remains grave and no sure cure has been found, certain definite lessons have been learned from these newer agents. In the first place, it is now evident that even acute leukemia can be rendered reversible, although this reversal at present is only for short periods. The fact that it is possible to reverse a disease which is normally so malignant offers hope that the disease at least will be controllable eventually.

Secondly, anti-leukemic drugs possess a cer-

(Continued on page 311)

BERT B. KUN, M.D.

Jersey City

Disseminated Myocardial Infarction*

A comprehensive description of the pathology, diagnosis and treatment of this rarely recognized form of myocardial disease is presented.

VARIOUS terms have been employed to describe a pathologic condition which in this paper shall be called *disseminated myocardial infarction*. Other terms are coronary insufficiency,¹ coronary failure,² atypical myocardial infarction,³ subendocardial focal necrosis, or subendocardial infarction. The confusion resulting from this varied nomenclature has produced a demand for clarification of this symptom complex.

Every acute attack due to coronary artery disease can be classified into one of three groups:

(1) *Myocardial ischemia*, also called angina pectoris, is an acute attack of myocardial anoxia initiating coronary spasms and chest pain. No matter how severe the attack may appear, however, the diagnosis is determined by the electrocardiogram. Without definite evidence of myocardial infarction, only the diagnosis myocardial ischemia is justified.

(2) *Disseminated myocardial infarction* is located mainly in the papillary-subendocardial layers (subendocardial dissemination) or involves the whole depth of the ventricular myocardium (intramural dissemination), but always in a patchy fashion. There is no occlusion of a coronary artery.

(3) *Transmural myocardial infarction* is a confluent or wall-to-wall necrosis of the ventricular musculature due to occlusion of a coronary artery.

A consideration of the second group is the purpose of this article. The name "disseminated myocardial infarction" was chosen because it combines the underlying physiology with the active pathology.

Disseminated infarction is a distinct clinical and pathologic entity. According to its clinical importance, prognosis and therapeutic management it is placed between the myocardial ischemia and coronary occlusion groups.

PATHOLOGY AND MECHANISM

THE pathology underlying disseminated myocardial infarction is coronary atherosclerosis associated with myocardial anoxia. When there is an increased demand for more oxygenated blood, the sclerotic and narrowed coronary arteries are unable to supply it. In patients with a diminished coronary reserve, an acute increase of myocardial anoxia, however slight, may cause diffuse coronary spasm. Disturbance of the myocardial equilibrium by a minute intimal hemorrhage may also induce an attack. The sensory nerves terminating within the hypersensitive ischemic myocardium carry reflex pain and produce a spasm of the affected coronary arteries.⁴ As a result, additional myocardial ischemia and more pronounced pain ensue.

Prolonged coronary arterial constriction—including the meta-arterioles and capillaries—causes distention and stasis in the capillary veins, beginning in the region of the arterio-

* From the Department of Medicine, Jersey City Medical Center.

venous capillary junction.^{4,6,13} This stasis, and the increased permeability of the coronary capillary system, results in extravasation of blood into the myocardium. This extravasation of blood is disseminated myocardial infarction.

Four mechanisms may be responsible for the trapping of blood in the capillaries: (1) defective vasomotor tone in arterioles, (2) augmentation of vasomotor tone with capillary anoxia, (3) direct capillary dilation, and (4) failure of the venopressor mechanism.⁴

CAPILLARY fragility or permeability is encountered even in otherwise healthy persons. An increase in hydrostatic capillary pressure may result from dilatation of arterioles or from active relaxation of the capillary walls themselves.⁴ It is known that hypoxia or anoxia increases the permeability of the capillary wall. Pronounced generalized capillary damage may also develop from changes in chemical environment or possibly nervous and hormonal action during shock.⁴ It has been demonstrated that oxygen want of only three minutes' duration multiplies the filtration through the capillary wall fourfold.^{4,6} Vitamin C deficiency, for instance, may also increase capillary permeability to a considerable degree.^{4,6}

In shock the leakage of plasma through the atonic and dilated capillaries is an accepted phenomenon. It has been shown that capillary walls are more permeable toward the venous ends than toward the arterial ends.⁴ In human beings dying from non-cardiac shock, extensive petechial hemorrhages were observed in the subendocardium as well.^{1,8} It has been suggested that subendocardial hemorrhage in shock is the result of sudden contraction of the heart which ruptures subendocardial capillaries already damaged by anoxia.⁹

THE capillary endothelial lamina in coronary atherosclerosis is particularly sensitive to capillary anoxia, congestion and changing capillary tension. Accumulation of blood in the capillaries increases the intracapillary pressure causing plasma seepage.^{4,6,13} Due to the sudden

generalized spasm of the coronary blood vessels, the meta-arterioles may lose their power of vasomotion and permit flooding of the capillaries.⁴ Simultaneous failure of the venopressor mechanism may enhance the capillary distention.^{5,6} Sympathetic nerves influence the capillaries directly or through control of meta-arteriolar vasomotion.^{4,6}

Although subendocardial infarctions without occlusion of a coronary artery have been demonstrated time and time again, the mechanism of this condition is unexplained. Levine wrote: "It is our impression that these cases represent a type of myocardial infarction of particular distribution and arising under particular circumstances."¹¹

Autopsy findings repeatedly have shown moderate papillary or massive subendocardial infarctions after a single attack of cardiac pain. Mild or extensive infarctions have also been described in patients where coronary atherosclerosis was found to be minimal.⁷

Since it has been proved by autopsy that one single attack can cause hemorrhage distributed around the whole circumference of the left ventricle, it is believed that infarcts developing simultaneously within the tributaries of all three major coronary arteries can only arise through capillary extravasation.

SITE OF DISSEMINATION

THE site of dissemination usually follows a certain pattern. It has been consistently shown that the left ventricular musculature is predominantly involved in infarctions and that myocardial pathology begins in the subendocardial region (i.e., the inner third of the ventricular musculature). The left papillary muscles are the most frequent site of dissemination although most of these cases show simultaneous dissemination into the subendocardial layers.^{7,11} The proximal or apical ends of the papillary muscles are most commonly damaged, but hemorrhagic spots at the base only, have also been encountered.⁷

This particular distribution is determined by the reduced capillary circulation within the subendocardial layers and the relatively inadequate oxygen supply of these regions. The

deep layers of the ventricular musculature, including the papillary muscles, have a reduced capillary collateral blood supply in comparison to the epicardial surface. Constant systolic contractions performed by the papillary muscles, however, require maximum nutrition.

This discrepancy between the amount of cardiac work and the available blood supply makes the deep layers particularly vulnerable to additional reduction of oxygenated blood. Furthermore, the intramural systolic pressure, which is greatest in the internal layers, increases the oxygen requirements of these parts. Relative lack of oxygen, therefore, causes more profound histopathologic changes in the subendocardial regions of the myocardium.^{7,10}

DISSEMINATION of infarcts progresses irregularly within this internal subendocardial layer and parallel to the subendocardial lining. In severe attacks it may involve, in a shell-like fashion, the whole inner circumference of the left ventricle. Between the endocardium and the scattered infarctions in the subendocardial layer there is a thin strip of undamaged myocardium preventing the extension of dissemination into the lining of the ventricular cavity (Figure 1).

The size of the infarcts is variable. They may range from a few small pinpoint-sized separate little hemorrhagic spots to irregularly confluent myocardial ecchymoses. Most frequently they are either petechial in character or have a diameter of approximately five millimeters.

If the subendocardial infarction is extensive, it often involves the middle third of the ventricular musculature, and if severe may reach the pericardial surface (intramural dissemination). Even in extensive disseminations, however, there are always islands of interwoven undamaged myocardium within the infarcted tissue. These spotty islands of healthy myocardium always differentiate this condition from the pathologic picture of massive transmural or wall-to-wall necrosis which usually follows coronary occlusion. The shape of these infarcts is like an irregularly-walled cone with its base

at the subendocardium and its apex toward the pericardium.¹¹ (Figure 1).

The similar basic pathology, favorable clinical course, good prognosis and characteristic electrocardiographic tracings classify these groups of infarctions as a separate entity within the family of acute coronary artery disease.

DIAGNOSIS

EACH patient with an acute coronary attack presents these diagnostic problems: (1) to verify the presence of a *disseminated* myocardial infarct, and (2) to determine the extent of dissemination.

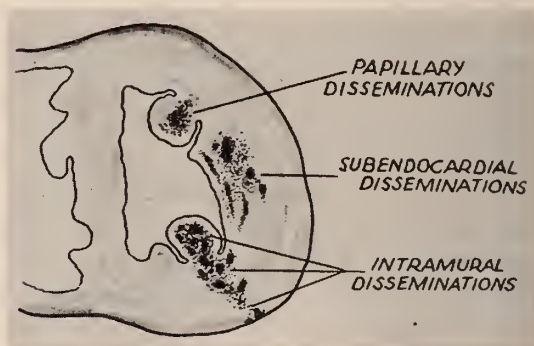


Figure 1. Schematic drawing (by F. Traugott) from a horizontal cut of the left ventricle showing three different stages of dissemination as seen during autopsy.

As a rule, there is a general relationship between the intensity of pain (i.e., the degree of myocardial ischemia) and the extent of damage. A similar relationship usually exists between the extent of dissemination and electrocardiographic findings. Thus, depending on the severity of the clinical picture and the electrocardiographic changes, the extent of damage frequently can be correlated.

Pain, as a rule, may be classified as mild, moderately severe or severe, corresponding roughly to papillary, subendocardial, and intramural dissemination.

Mild attacks of pain with little or no radiation usually indicate relatively slight dissemination. These are located mostly in the left papillary muscles or are isolated petechial hemorrhagic spots within the subendocardial layers. (Figure 1, papillary disseminations).

Moderately severe attacks of pain may be associated with radiation, perspiration, and a distressing clinical course. The disseminations within the subendocardial layers are more extensive and may involve a considerable part of the left ventricular musculature. This combination of papillary-subendocardial dissemination is most commonly encountered. Recent publications reveal the true nature of this type of myocardial pathology.^{7,11} Patchy dissemination within the inner third of ventricular musculature with healthy myocardial islands in between are clearly demonstrated. The disseminations are either localized with distribution "in depth" (Figure 1, subendocardial dissemination), or involve the internal third of the myocardium circumferentially and parallel to the endocardium.

Frequently the whole inner shell of the left ventricle shows fresh disseminations. Since the differentiation between degree of pain and extent of dissemination often is unreliable, an assumption of papillary-subendocardial dissemination is justified in the large majority of patients with a moderately severe clinical course.

Severe attacks of pain associated with a serious clinical picture indicate very extensive dissemination within a large portion of the left ventricle and in all myocardial layers (intramural dissemination). The pains are prolonged and may recur many times daily and also during sleep. They may start all over again after several days of a pain-free period despite restricted activity. This acute stage may last for one week or longer. In these severe infarctions necrosis of the myocardium frequently occurs causing irreversible myocardial fibrosis.

THIS condition is often indistinguishable clinically from an acute occlusion of a coronary artery. A differential diagnostic feature may be the frequent observation that in disseminated infarctions, during the pain-free period, patients feel well and do not look very ill. These intramural hemorrhages may reach the epicardial layer in spots (Figure 1, intramural dissemination), but confluent or massive pericarditis is not encountered.

There are, however, frequent exceptions. In-

dividual reactions to pain and corresponding overlapping of disseminations from one myocardial layer to another make the exact visualization of the pathologic process at times difficult.

For instance, following a single attack simultaneous disseminations into the whole depth of the ventricular muscle may occur. Mild infarction at the start may progress further intramurally without concurrent aggravation of the patient's clinical condition. Recurrent "anginoid" pains of different intensity following the acute attack or during convalescence may or may not be caused by additional new disseminations anywhere within the ventricular musculature. Laboratory and electrocardiographic evidence of additional myocardial damage is frequently lacking where clinical symptoms indicate extension and vice versa. Subjective symptoms may be misleading in a hypersensitive patient. The myocardium of atherosclerotic patients, as a rule, is quite sensitive to disturbances of its equilibrium. Irritation from emotion or excitement, the slightest increase of myocardial ischemia, or minute subintimal or subendocardial hemorrhages, may also give considerable discomfort.

ON THE other hand, patients sometimes complain of indefinite clinical symptoms like perspiration or weakness, mild transient dyspnea, or short palpitations. Although no pain is experienced, the electrocardiogram may show active myocardial damage. Occasionally, even an extensive infarction will cause little or no pain (silent coronary occlusion).

For these reasons, the history, the clinical course of the patient, the electrocardiogram, the objective signs and the laboratory findings, must be considered collectively. Evaluation of all diagnostic criteria will lead to rational therapy.

The following points are discussed from this differential diagnostic point of view.

Electrocardiogram. The most important diagnostic tool is the serial electrocardiogram:

(1) It differentiates reliably in most cases between the three types of acute attacks of cor-

onary artery disease—reversible myocardial ischemia, disseminated infarction, or transmural infarction. (2) When evaluated with the clinical picture the electrocardiogram may also indicate the extent of the disseminated infarction. Its most significant features in this respect are the depth of the precordial lead S-T depressions and T-wave inversions, and retrospectively, the elapsed time between the acute attack and the beginning of ST-T reversion toward normal.

*I*N A mild attack the electrocardiographic changes may be trivial. There is slight S-T depression followed by T-wave inversion, both not more than 0.1 millivolt, in one or two leads which start reverting toward the iso-electric line within the first week. The mild clinical course with the quick improvement in the electrocardiogram permits the conclusion that these patients had only a few isolated, petechial non-necrotizing disseminations.

A moderately severe clinical course shows deeper S-T depression and T-wave inversion. The depth of these changes usually does not surpass 0.3 millivolt. ST-T changes in all precordial leads signify extensive subendocardial distribution in a shell-like fashion. If present only in two or three leads it is a localized dissemination "in depth" (Figure 1). As a rule, no Q waves are seen.

Occasionally, during the acute stage, slight S-T elevations, usually in one lead, are encountered. Continued evaluation of the clinical picture and the serial electrocardiographic changes, particularly the beginning of S-T recession, will often clarify the extent of the damage. If ST-T changes fail to show improvement even after a few weeks following the attack, the diagnosis of moderately severe infarction is justified. Many tracings return eventually to normal configuration, however, proving the non-necrotizing pathology of most of these disseminations.

*I*N A severe attack the serial electrocardiogram offers the most reliable clue to the severity of dissemination. The tracings will show very

deep S-T depression and more pronounced T-wave inversion, both deeper than three millimeters, but because of the scattered and undamaged myocardial islands within the affected ventricular musculature, significant Q waves do not develop. Very extensive disseminations may involve the pericardial surface in a patchy fashion. In these cases small Q waves do appear, but are always less than three millimeters deep and are present only in occasional precordial leads.

It must be emphasized, however, that due to the many clinical variations there may be corresponding electrocardiographic deviations and exceptions. Electrocardiographic changes may occur immediately or they may not appear for a week or more. In about 10 per cent of patients the electrocardiogram fails to reveal active myocardial damage. As a general rule, ST-T changes which are due to disseminated infarctions very frequently return to normal configuration. In severe disseminations, however, S-T depression and T-wave inversion may be present years after the attack or may never return entirely to normal. The clinical progress of the patients usually goes hand in hand with the return of the ST-T segment toward the iso-electric line.

Shock and Friction Rub. A very distinguishing clinical feature in differentiating intramural dissemination from transmural infarction (coronary occlusion) is the absence of severe shock and friction rub. It has been shown recently again¹² that disseminated infarcts do not reduce the contractile power of the left ventricle during systole. Even in extensive intramural dissemination a sufficient amount of viable muscle fibers remains to permit adequate left ventricular systolic output. The blood pressure may become labile during the acute stage, but returns to normal or almost normal levels within a few hours or days. In severe dissemination the blood pressure may be on the subnormal side for weeks. However, severe protracted hypotension with shock or cardiac failure does not develop.

After an arterial occlusion the ventricular musculature becomes transmurally necrotic and

loses its contractility. The absence of concentric and uniform ventricular contractions during systole has been demonstrated conclusively. Instead, the necrotic myocardium appears atonic and "herniates" during each systole. Thus the ventricular beat becomes hypodynamic. Ventricular pressure, pulse pressure, and arterial pressure diminish and less blood is expelled. Myocardial reserve is reduced considerably. Congestive failure and shock may develop.

FRICTION rub is diagnostic of pericardial involvement. Since the disseminations are almost exclusively within the inner regions of the myocardium the pericardium, as a rule, is not involved. In severe intramural dissemination, patchy pericardial distribution may occur, but not extensive enough to cause an active pericardial reaction. After massive transmural infarction, however, the pericardial surface becomes necrotic, localized pericarditis with or without hemopericardium occasionally develops and a friction rub is frequently heard.

Gastric Symptoms. Gastric symptoms may complicate the acute stage, particularly in an over-anxious patient, but they frequently signify more profound myocardial damage. The discomfort is considerable and patients often have found it more distressing than cardiac pain. It has been shown that mental distress invariably reduces the tonus of the stomach and the amplitude of its contractions.¹³ Vagus and sympathetic stimulation by the infarcted myocardium depresses stomach motility and causes spastic contraction of the sphincters.¹³ The desire and the inability to eruct air is the most distressing symptom. During the acute stage the patient may obtain relief through a liquid diet, oxygen, and atropine.

Temperature. The absence of fever in ischemic attacks and the presence of fever in infarctions offer a certain measure of differential diagnosis. However, the degree and duration of fever might be similar in all forms or stages of infarction and is an indefinite diagnostic sign. For instance, it has been frequently

observed that a mild dissemination with a favorable clinical picture and only slight electrocardiographic changes has still caused temperature elevation for many days. More severe damage, whether disseminated or transmural, usually causes fever lasting about one week.

Laboratory Findings. Leukocyte counts and sedimentation rates are also very indefinite, and in themselves are not diagnostic. In pain due to acute ischemia both examinations are normal. In infarctions one or the other or often both will be elevated. But both tests may be within normal limits in spite of severe myocardial damage.

Mural Thrombi and Thromboembolic Complications. These do not occur in disseminated myocardial infarction. It has been shown that a thin layer of healthy endocardial lining is present even in extensive subendocardial dissemination. Consequently, mural thrombi within the left ventricle do not develop and embolic complications are absent. In disseminated infarctions there is no occlusion of a coronary artery and therefore no intra-arterial thrombus propagation is possible.

Transmural infarctions following coronary occlusion initiate through-and-through necrosis frequently causing mural thrombi and embolic phenomena.

PROGNOSIS

THE absence of mural thrombi, severe shock and cardiac failure generally present a favorable prognosis in all groups of disseminated infarction, even when severe. The absence of extensive irreversible myocardial necrosis allows complete myocardial recovery in the majority of patients.

Occasionally sudden death has been reported where autopsy failed to show occlusion of a coronary artery. At times minor petechial disseminations were found in patients who had only slight or moderately severe atherosclerosis with patent coronary arteries.⁷ It is believed that in these instances a sudden complete paralysis of the conduction mechanism and not the extent of the dissemination is the cause of death.

THERAPY

THE primary consideration in the acute attack should be the earliest possible termination of the coronary spasm through vasodilation. The sooner myocardial oxygenation improves, the less chance there is for extensive myocardial damage. Nitrites (nitroglycerine; amyl nitrite inhalations) are the treatments of choice.

Nitroglycerine tablets, 0.3 or 0.6 mg. (grain 1/200 or 1/100) depending on the pain intensity, are given at the start of substernal or precordial pain and repeated every ten minutes until the pain subsides. Severe hypotensive states are not encountered no matter how many nitroglycerine tablets are taken. Occasionally, in severe attacks oxygen proves beneficial. Demerol® or morphine are rarely necessary and are given primarily to the overanxious or hyperirritable patient.

For gastric symptoms atropine by mouth or oxygen usually gives quick relief. Mild sedation is started immediately and Seconal®, 0.1 gram given nightly. After the acute pain has subsided pentaerythritol tetranitrate (Peritrate®), ten milligrams or triethanolamine trinitrate biphosphate (Metamine®), two milligrams three to four times daily, is given continuously.

OCCASIONALLY, in severe intramural disseminated attacks of arrhythmias have been encountered. Quinidine sulfate, 0.2 gram every four hours, is given and discontinued as soon as the regular rhythm returns.

Rutin with ascorbic acid may be beneficial to decrease capillary permeability.

Bed rest for one to three weeks depending upon the clinical condition and the extent of electrocardiographic change is advised. Mild attacks with insignificant electrocardiographic changes require at most one week of bed rest. The largest group, with moderately severe pain attacks and less than three millimeters ST-T displacement, requires approximately two to

three weeks in bed. More than three weeks is seldom necessary except in severe cases of disseminated infarction. During this time movement of the extremities and turning from side to side are encouraged. Bathroom privileges are allowed if the clinical condition permits.

SINCE there is no occlusion of an artery, there is no danger of proximal propagation of a thrombus. Not having mural thrombi, no danger of embolization is present. For these reasons, anticoagulant therapy is not indicated.

Admittedly it may become difficult to differentiate in the acute stage between a severe disseminated infarction and a transmural infarction. Anticoagulant therapy is advised until a definite diagnosis is possible. The clinical course and serial electrocardiograms showing the absence of deep Q waves and S-T segment elevation will usually verify the diagnosis within the first week. The anticoagulants then can be discontinued. Since even extensive hypoprothrombinemia does not increase the extent of myocardial infarction,^{14,15} temporary anticoagulant therapy should not be considered deleterious.

CONCLUSION

AN ACUTE coronary attack may cause disseminated infarction from petechial size to larger confluent hemorrhages within the left ventricular musculature. Situated between these hemorrhages are always islands of undamaged myocardium. The concept of the pathogenesis of these disseminated hemorrhages is capillary stasis with increased capillary permeability and extravasation of blood. This is a distinct clinical and pathologic condition with a generally benign clinical course. Although the etiology is coronary atherosclerosis there is no occlusion of a coronary artery. There are no thromboembolic complications, the prognosis is favorable, and the mortality is minimal.

A new classification of coronary artery disease is presented.

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Control of Leukemia

(Continued from page 303)

tain degree of specificity. Aminopterin® is most useful in the acute lymphocytic leukemia of childhood, TEM in chronic lymphocytic leukemia and lymphosarcoma and myleran in chronic granulocytic leukemia. It is thus possible that a specific agent may be found for each form of this disease.

Finally the anti-leukemia drugs act through entirely different mechanisms. Aminopterin® owes its activity to its antagonism to folic acid, ACTH because it inhibits lymphocyte production and 6-mercaptopurine to its activity as an antagonist to nucleic acid production. All of

these drugs, except ACTH and cortisone, are myelotoxic. Thus any agent which is therapeutically valuable must apparently be myelotoxic.

Dr. Dameshek summarizes by saying that leukemia, although at present a hopeless disease, may eventually become one which can be controlled. Moreover, since the control of leukemia represents the control of a neoplastic disease where the cells float free in the blood stream, it is possible that when leukemia is controlled progress will be made in the management of cancer itself.

R.D.G.

FRED B. ROGERS, M.D.*

Trenton

Opifer Per Orbem Dicor

The seal of our society is steeped in classical tradition and stands as an inspiration today. Its history is traced in this essay.

USE of a seal for purposes of identification and decoration dates from remote antiquity. In the orient the age-old custom of employing a distinctive stamp for authentication is similar to the western habit of inscribing a signature. Seals have long been used in Europe and America for the same purpose by states, officials and organizations. The practice of affixing a seal to important documents in medical circles continues to be popular. At present a seal is used by the American Medical Association, by numerous state societies including that of New Jersey, and by eleven county medical societies within our state itself.

The seal of The Medical Society of New Jersey, a device almost two hundred years old, not only represents the first organization of its kind in America, but also connects our organization to a rich inheritance from the past.

A distinctive seal for The Medical Society of New Jersey was first proposed at the annual meeting held in Princeton on November 7, 1786. The following entry was recorded in the *Transactions* on that date:

Ordered that a seal be made for the use of this Society; and that Dr. (Isaac) Smith, Dr. (Thomas) Wiggins and Dr. (John) Beatty be a committee to procure said seal and affix what device they think proper.

The committee consisted of three past presidents of the Society, men qualified for the task



Figure 1.

by classical education at Princeton and Yale (Dr. Wiggins). Progress was reported by the committee at subsequent meetings and a seal finally adopted on May 4, 1790. At that time an embossing press was also secured. The original seal, with slight alteration, was again adopted in the semi-centennial year of the Society (1816) on recommendation of another committee of past presidents. The latter design, without further modification, is still used by the Society (Figure 1).

* Fellow in Medicine, Temple University School of Medicine, Philadelphia, Pa.

The author wishes to acknowledge the assistance of Henry R. Rollin, M.D., D.P.M., of London, England.

THERE is no specific description of the original seal in the early records, but no reference to any change in its appearance appears subsequently and no evidence is found for any other device than that used to this day. While attractive from an artistic standpoint, its inherent beauty is that it exemplifies the idealism of the founders of our medical society. A symbol which links the present with the past, it also conveys to the future the aims of the medical profession and of a pioneer medical organization.

Our seal depicts the oracle in the Temple of Apollo, chief god of healing in antiquity. The high priest at Delphi is shown delivering a prophesy as he stands beside the altar. Above him shines the light of inspiration — rays from Apollo, also legendary god of the sun. The Latin inscription above the columns is a quotation from the Roman poet, Ovid (43 B.C. - 17 A.D.), who wrote during the reign of Augustus. This motto consists of words ascribed to Apollo by Ovid in his epic poem *Metamorphoses* (I, 521-522):

Inventum medicina meum est,
Opiferque per orbem dicor,
et herbarum subiecta potentia nobis.

"The art of medicine is my discovery," said the god, "and I am known throughout the world as one bearing aid; and the virtues of all the herbs are known to me."

IN THE colorful legends of Greek mythology, born in the dawn of civilization, Apollo, god of fine arts and medicine, healed the wounds and diseases of the Olympian gods with peony root. From this herb was derived his name "Paeon," and the designation, "sons of Paeon," as applied to physicians. Apollo, moreover, had a favorite son, Aesculapius, upon whom he bestowed the divine gift of healing. Aesculapius, later the Roman god of medicine, was reared by Chiron, who excelled not only in surgery but also in music and history. To this day Chiron retains his place in the heavens as a star.

The daughters of Aesculapius—Hygeia, goddess of health, and Panacea, healer of the sick—in turn were reputedly ancestors of Hippo-

crates (460-370 B.C.), the mortal father of medicine. The oath of Hippocrates, a common promise of physicians throughout recorded history, begins with the clause, "I swear by Apollo, the physician"—the same patron whose lofty motto appears on our seal.

A similar spirit of professional idealism appears in the inscription on the altar of Apollo's shrine. This is an abbreviation for "*cortina merces anti*"—a slogan which may be translated, "The oracle of Apollo is opposed to commercialism." (*Cortina* is the technical term for the tripod-caldron of Apollo, and *merces* a word denoting an unrighteous reward or bribe.) The legend below the altar—*Nov. Cesariensis M. S. Sigillum*—stands for "The Seal of The Medical Society of New Jersey."

An interesting similarity exists between this seal and the arms of the Society of Apothecaries of London, a still-flourishing organization incorporated by royal charter in the year 1617. These emblems symbolically connect the first state medical society of the American Colonies with the earlier professional body in England. An identical motto from Ovid, "*Opiferque per orbem dicor*," and the sharing of a common patron, Apollo, link the two devices.

THE ancient arms of the Society of Apothecaries of London show Apollo astride a medicinal serpent and adorned with leaves of laurel, his sacred tree. Surrounded by two unicorns and a rhinoceros—relics of therapeutic superstition—he holds a bow and arrow in his hands. (Apollo was commonly called *Alexikakos*, "avert of ills," by the ancient Greeks. Given the power through his far-darting arrows to visit diseases upon mankind, the god could, at need, also avert them.)

The arms of the Society of Apothecaries of London were often reproduced in the eighteenth century on decorated pill slabs which were presented to new members of the guild. When not used for mixing and rolling pills, these slabs were displayed as a sign of membership in the society. This august body was undoubtedly familiar to the founders of The Medical Society of New Jersey, especially to those members who had studied abroad.

Since early in the eighteenth century, in fact, the apothecaries of London had been allowed to prescribe as well as dispense drugs, thereby becoming general medical practitioners — a role still filled by them to this day. (Perhaps the best-known member of the Society was the poet-physician John Keats, who was licensed to practice medicine by the Apothecaries in 1816).

Like its lineal descendant in America, the Society of Apothecaries of London was formed as a direct result of a desire for better medical education and practice. Throughout a long career its chief concern has been the advancement of medical education and the recognition of its members by the profession. Not only does the seal of The Medical Society of New Jersey somewhat resemble the arms of its forerunner in England, but also a similar progressive attitude has existed in the American organization from its earliest days.

THE seal of The Medical Society of New Jersey was frequently printed in the early records of the Society. Its size was sometimes two or three inches in diameter. It was often printed with a black background, on which the device and inscription appeared in white. Sometimes it was printed in black lines on a white background, as it is today. The original seal was affixed by impression to early ornate membership certificates, written in Latin. The form of these credentials was printed in the *Transactions* for 1790 and subsequent years. Later, after the authority to award the degree of *Medicinae Doctor* was granted to the Society in 1825, the seal appeared on its M.D. diplomas—the last one, an honorary degree, being conferred in 1902.

The seal also has been prominently displayed on publications of the Society throughout their long history. It appeared on the title page of *The New Jersey Medical Reporter*, a quarterly journal edited by Dr. Joseph Parrish at Burlington during the years 1847-1858. The same device was also frequently reproduced in the annual volumes of the *Transactions of The Medical Society of New Jersey*, issued from 1859 through 1903. The seal has appeared on page one of the *JOURNAL*, the first number of

which appeared in September, 1904. Today the *Membership News Letter*, *Membership Directory*, Fellow's Key (a key presented to each ex-president of the Society), honorary membership certificates and all official stationery also display the venerable seal of the Society.

THE original seal did not bear the title "The Medical Society of New Jersey," in English words. These words and the founding date, 1766, were added in conspicuous type encircling the original emblem at a relatively recent date. This form of the seal has been printed near the bottom of the cover page on each issue of the *JOURNAL* since January, 1936. The same style seal also appears on the current membership plaque presented to each member of the Society.

Apart from the complete seal, our ancient motto has served in many ways to enrich the medical literature of New Jersey. At the Centennial Meeting of the Society, held at Rutgers College on January 23, 1866, the President's Address, in unique verse form, was inspired in part by this maxim. The Centennial President, the celebrated physician-poet Dr. Abraham Coles, first read his "physiological poem," *The Microcosm*, at that meeting. He included in this work a section entitled, "*Charity-physician-Opiferque per orbem dicor.*" The familiar motto was used by Dr. Coles to emphasize the fact that for twenty-five centuries the medical profession had been recognized as bearers of aid to suffering humanity. This responsibility, he added, had been undertaken willingly by physicians and performed to the best of their abilities as a contribution to the making of a happier world.

AT THE same centennial celebration, Dr. William Pierson, secretary of the Society, traced its first century of progress in an interesting "historical narrative." Steeped in classical learning as were most physicians of that time, Dr. Pierson could reliably criticize the Society's motto for a minor inconsistency. "This quotation," he said, "if literal, is not strictly grammatical, and certainly inappropriate. The con-

junction *que* affixed to the word *opifer*, is without an antecedent word to be connected. It would be well in the future that this error be corrected" (to *Opifer per orbem dicor*). Later in the same record, however, the motto (without this suggested correction) appeared as a banner leading a crusade for public health reform. In subsequent *Transactions* its sentimental appeal was often utilized in similar fashion.

Years later, Dr. Elias J. Marsh, one hundred and fiftieth president of the Society, employed the motto as the title of his presidential address. This inspiring oration, "*Opiferque Per Orbem Dicor*," was delivered during the second world war and printed in the *JOURNAL* for July, 1943. Still timely today, it reflected the idealism attributed to members of the medical profession. Dr. Marsh pointed with pride to the first medically-sponsored, voluntary health insurance program in the United States, the Medical-Surgical Plan of New Jersey, organized by The Medical Society of New Jersey in 1938. Such illustrious precedents, he

said, continued to fulfill the spirit of the Latin motto on our antique seal. Inspired by its past, he added, the medical profession looked steadily toward the future. An amalgam of old and new, the seal of this pioneer organization, through its symbolism, emphasizes for each physician the dignity and responsibility of the medical calling.

THE closing paragraph of the Centennial Narrative (1866) of The Medical Society of New Jersey offers a succinct conclusion to this study of our seal. Ending on a lofty note, its words are still applicable as the medical profession in New Jersey nears a second centenary of achievement:

Let then, the membership, . . . by every good word and work, receive with favor and pursue with alacrity whatever promises to advance the dignity, the honor, and the utility of our calling; never forgetting the beneficent sentiment of the Roman poet, whose language we have borrowed for our motto, "*opifer per orbem dicor*."

Donnelly Memorial Hospitals

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JOHN R. O'BRIEN, M.D.
Jersey City

Efocaine in Pruritus Ani

Efocaine® was found effective in controlling pruritis ani in 73 out of 85 patients. Careful adherence to technical details will prevent untoward complications.

THE widespread occurrence and refractory character of pruritus ani combine to make this disorder a most perplexing problem.

A multitude of procedures are in use for the treatment of ano-rectal itching. Radiation, injections of alcohol, anesthetic-in-oil preparations, oxygen, saline solution and various surgical procedures often only allay the symptoms temporarily and frequently result in scarring and other undesirable side effects.^{1,2} Topical dermatologic medications, on the other hand, not only tend to lose their effects, but often aggravate the condition.

Our interest was aroused, therefore, by recent reports,³⁻⁸ advocating Efocaine®* to attain prolonged local anesthesia of 6 to 12 days' duration. This preparation has been used successfully to control postoperative ano-rectal pain and to relieve pruritus.⁴⁻⁸ A study was initiated to evaluate Efocaine® in the management of pruritus ani.

METHOD

EIGHTY-FIVE pruritus ani patients, ranging in age from 26 to 66 years, were randomly selected for treatment. The group included 47 males and 38 females, and of the latter, 6 were suffering from pruritus ani et vulvae.

All patients were ambulatory, and were

treated during office visits. On the occasion of the first treatment, only the one or two most pruritic quadrants were injected with Efocaine®. Usually this procedure served to bring under control the pruritic stimuli of the entire affected area. However, if necessary, the remaining quadrants were injected on subsequent visits, preferably one quadrant at each visit.

TECHNIC

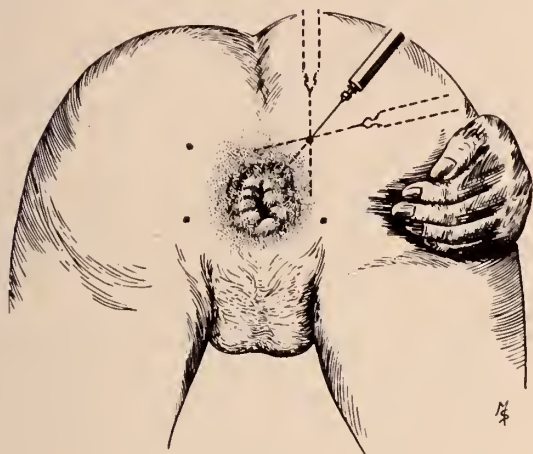
PRIOR to the injection of Efocaine®, a skin wheal is raised with 1 or 2 cc. of a 1 per cent aqueous procaine hydrochloride solution, just beyond the pruritic zone, (and at a position approximately equivalent to 1, 4, 7 or 10 on the "anal clock"), depending on which quadrant has been selected for treatment.

Efocaine® is then injected through the skin wheal using a 24-gauge, 3-inch needle. It is important that the anesthetic be injected into the deeper subcutaneous tissue at a depth of at least one-quarter to one-half inch. Intradermal injection should be carefully avoided, as well as pooling of the agent at any one site.

The Efocaine® is deposited in a fan-wise manner in the quadrant or quadrants to be treated. Injection is made slowly and continuously during withdrawal of the needle to the skin surface and is stopped just before the superficial layer is reached. Without further

* Manufactured and distributed by E. Fougera & Co., Inc., New York, N. Y.

withdrawal of the needle, it is again reinserted in another direction and the process repeated until a series of fan-wise lines is accomplished (Figure 1.).



In the more severe cases, a small quantity of Efocaine® may be injected intramuscularly into the sphincter, using the finger as a guide to prevent penetration of the rectal mucosa. Two to three cc. are usually sufficient for the complete injection treatment of a single quadrant.

RESULTS

IMPROVEMENT of the pruritus occurred in 73 of the 85 patients treated with Efocaine®. The results are given in detail in Table 1. Included in this group were five patients in whom the symptoms had existed for 10 to 18 years and had been found refractory to other methods of treatment which, in two cases, had included x-ray therapy.

Another 41 patients (48 per cent) experienced substantial improvement of the pruritus, and there was no relapse of the condition during the period of observation—five months in one case; four months in five cases; and three months in the remainder. One patient showed good improvement after three injections of Efocaine® but did not return for further treatment and could not be observed beyond the second month.

A third group of 17 patients (20 per cent)

TABLE 1. SUMMARY OF RESULTS OBTAINED BY THE TREATMENT OF 85 PRURITUS ANI PATIENTS WITH EFOCAINE®

Initial Condition of Skin	No. of Patients	Sex Distribution	Age Range Years	Average Pruritic Duration and Range Years	Average Number Injections per Patient	Average Period of Observation Months	Marked Improvement	Improved; No Relapse	Slight Improvement	No Improvement	Remarks
Chronic	17	M 15 F 2	31-66	7.11 (2-18)	4	3	7	6	3		1 patient initial improvement, then slight relapse
Skin changes	24	M 16 F 8*	26-66	3.1 (1-10)	4	3	4	6	7	6	1 patient improved but stopped treatment
Macerated								16	5	3	
Mild Skin changes	25	M 12 F 14†	28-60	(0.5-1) (0.5-2)	2	3	1	13	2	3	
No Skin changes	19	M 4 F 15**	26-60	0.66 3-1	4	3	4	4	17	12	
Total	85	M 47 F 38					13	41	17	2	

* Including 2 patients with pruritus ani et vulvae.

** Including 1 patient with pruritus ani et vulvae.

† Including 3 patients with pruritus ani et vulvae.

was slightly improved at the end of the observation period (four months in one case, and three months in the others). In one case, the pruritic condition was initially improved, but a relapse took place during the subsequent four months. In 12 cases (14 per cent) no particular improvement was noted. No local or toxic effects of any nature resulted from the use of Efocaine® in these patients.

DISCUSSION

THE results of this study reveal Efocaine® to be a highly useful preparation for the management of pruritus ani. With careful adherence to minimal dosage as well as to technic, the injection of the drug is simple and may be readily done as an office procedure. The patient undergoes relatively little discomfort during the injection of Efocaine®, and usually within a short time he experiences dramatic relief from itching which persists over a period of days.

Although there have been some reports in recent medical literature¹⁰⁻¹³ concerning neural and tissue damage, no untoward side-effects have been noted by this author in this series, nor in the many additional cases since this paper has been submitted. Return of sensory perception was invariably noted after a period of ten to fourteen days, which would appear to be sufficiently indicative of the lack of significant nerve or tissue damage.

It should be noted, however, that the complications reported in the literature generally did not concern themselves with ano-rectal usage. These untoward reactions primarily related to the injection of this drug, in close proximity to the spine, suggesting inadvertent intrathecal entry of the drug. While several mechanisms for these complications have been suggested,^{10,11,12} it is obvious that these technics do not apply to the local infiltration of Efocaine for ano-rectal pruritus. It should be emphasized that the neurologic complications reported were concerned with motor nerve innervation, for which the drug is contraindicated.

These same reports also noted the occurrence of tissue slough and localized reaction after ano-rectal usage. These complications are well known to the proctologist, and have occurred even when no medication was used.¹⁴ The cause for these reactions, which have been observed for many years, is so varied that to limit this cause to a single factor is unscientific.

However, it should be pointed out that careful adherence to dosage and precautions noted are as much a prerequisite for this drug as for any other parenteral drug which the physician is called upon to use. Efocaine®, by reason of its depot-mechanism, requires special handling and should not be confused with other local anesthetic preparations. Thought should likewise be given to the motor innervation of the area to be injected. Motor nerves should be meticulously avoided.

Efocaine® should not be considered a curative agent for pruritus ani. The complete relief of itching, which it is capable of inducing, endows the drug with a value over and above that of a simple palliative agent. By interrupting the "itch-scratch, scratch-itch" cycle, it halts excoriation of the affected area and encourages normal healing of the damaged tissue.

SUMMARY AND CONCLUSIONS

1. Eighty-five pruritus ani patients were treated by local infiltration with Efocaine®.
2. Improvement of the pruritic condition occurred in all but twelve cases. Thirteen patients showed marked improvement, forty-one were improved and seventeen were slightly improved. One patient was improved initially but suffered a relapse during the observation period. In one case, improvement of the pruritus occurred, but the patient stopped treatment too soon to warrant conclusions regarding efficacy of treatment.
3. No local or systemic toxic effects resulted from treatment with Efocaine®.
4. Efocaine® is a useful and safe agent in the management of pruritus ani, when precautions as to dosage and technic are observed.

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Rupture of Inferior Epigastric Vessels

Murray and Burger* have called attention to rupture of the inferior epigastric vessels as a surgical entity in the *Annals of Surgery*, January 1954.

The primary symptom of rupture of the inferior epigastric vessels is pain in the right or left lower abdominal quadrant. Nausea, vomiting, poor appetite and constipation may be present. The onset may be either sudden or gradual.

Physical examination shows a tense tender mass palpable either to the right or left of the midline in the lower abdomen. The mass is fixed and may be accompanied by a spasm and rigidity of the muscles. There may also be slight to moderate intestinal distention and decreased peristalsis. Ecchymosis of the abdominal wall has also been reported.

If the palpable mass remains unchanged when the patient sits up and is immobile the

diagnosis becomes more definite. Rarely shock, fever and leukocytosis are present.

This syndrome occurs more commonly in middle-aged patients. Signs of other arterial and venous disease may be found. Laboratory and x-ray findings are usually negative and thus aid to eliminate other conditions.

Treatment may be conservative, consisting of pressure with a tight abdominal binder. However, the majority of surgeons feel that a direct surgical attack is the safest and surest treatment. A blood clot left in the tissues may cause pain, abscess formation and other complications. Moreover, a surgical exploration obviates the occasional case of erroneous diagnosis.

*Murray, S. D. and Burger, R. E.: Rupture of the Inferior Epigastric Vessels. *Ann. Surg.*, January 1954.

JOSEPH BROADMAN, M.D.

New York, N. Y.

Local Therapy of Chronic Non-rheumatoid Arthritis and Rheumatism

A novel treatment of non-rheumatoid acute and chronic joint disorders is proposed in this preliminary report.

THIS clinical report describes, with case histories, a method of treating certain types of non-rheumatoid arthritis and rheumatism which has brought promising results in hundreds of patients.

The method was developed by Dr. G. Laughton-Scott, a distinguished London (England) physician, who died in April 1953, after more than twenty years of research in the treatment of rheumatic diseases. Prior to his death, Dr. Scott had drafted plans for introducing his technic to America, and his passing doubtless is one reason why his method is still comparatively unknown in this country.

The Scott¹⁻⁷ method has produced results in the treatment of the following: fibrositis, sciatica, brachial neuritis, intercostal neuralgia, and osteo-arthritis.

The therapy consists of weekly injections, for about six weeks, of a 5 per cent solution of camphor and salicylates in oil. As a rule it is possible to discharge patients after approximately six treatments. The dosage varies with the severity. Frequently, less than six treatments suffice; rarely, more than six are needed.

The drugs used are devoid of the dangers inherent in certain drugs and hormones now employed. However, a thorough knowledge of the technic is the key to successful treatment. Mapping of the rheumatic geography must be

exact and complete. Patients cannot be entirely relieved if a single lesion is overlooked. Ordinary physical treatment does not demand the same meticulous definition. Idiosyncrasy does not occur with this method, though tolerance may vary. Malaise and pyrexia may follow the initial treatments, but the effects soon pass. Actual pain, if any, can be controlled easily with simple analgesics. With the proper technic and correct doses, the prognosis of the types of rheumatic disease to which this treatment applies become markedly improved.

The actual technic can best be learned while observing its application by someone already experienced with it.

TECHNIC

IN CASES of rheumatic fibrositis the injections are made deep into the tissues, so that the medication spreads over the periosteum, close to the bony origin of the affected muscles. A long enough 19 gauge needle should be used. Each fibrositic lesion must be treated separately. As many lesions are treated at one time as the patient can tolerate. Accurate surface marking for determining the site of injections in relation to the signs and symptoms determines the results.

With rheumatic sciatica the injections are made deep into the gluteal muscles, at the sciatic notch, directly into the periosteum of the notch. Drawing a line between the top of the greater trochanter of the femur and the tuberosity of the ischium, the injections are made at a point between the inner and middle thirds of that line. At the same time, an injection is made to the transverse process of the fourth and fifth lumbar vertebrae of the affected side.

With brachial neuritis, we find the point of severest pain upon pressure on either side of the cervical vertebrae. The injections are made directly into the deep tissues as far as the bony structures underneath, about one half inch from the median line in order to avoid the spinal column.

With intercostal neuralgia, we locate the point of greatest pain and inject into the muscle down to the periosteum of the corresponding rib. Care should be taken not to puncture the pleura.

OSTEoarthritis is treated by injections directly into the affected joint. In the knee it is made on either side of the ligamentum patellae, the knee being flexed to as nearly 90 degrees as possible. In the shoulder joint the injections can be made from the front, one half inch outside and one half inch below the coracoid process of the scapula, with the arm rotated outwardly. A similar procedure is followed with other joints.

In all instances, the injection of a local anesthetic should precede each treatment, except in the knee joint, where none is needed. Only when it is necessary to inject directly into the thick parts of the ilium, the top of the tibia, the top of the femur or into the occiput, is a general anesthetic needed. Similarly, whenever mass injections are given, general anesthesia should be employed. A finer needle is used when injecting smaller joints.

A definitive evaluation of the Scott method had been incorporated in the report of a special committee of the London Medical Society in 1951. This report was the outgrowth of a clinical study made by four eminent specialists

appointed by the Society in 1949 to make a thorough inquiry into Dr. Scott's method. Two years were required to complete the study. During this period the four physicians treated about 200 cases of fibrositis, using the method described by Dr. Scott. At the completion of the clinical study, the committee submitted a report to the Society stating that 78.5 per cent of the cases treated by them were either "free of symptoms" or "plus improved." The entire group of patients was followed up, some as long as 15 months and at the time the report was rendered, the committee found that there had been no change in the condition of any of the patients since discharge. The committee's report was published in the *Lancet*⁵ which stated in part:

The average duration of symptoms was 3.1 years; the average number of injections per case was 5.9 and the average follow-up time 8.9 months (minimum 6 and maximum 15). The long interval between the end of treatment and the follow-up, seems to us to enhance the significance of the improvement recorded.

The injections were given once a week, unless the patient had a strong reaction accompanied by malaise. This malaise appeared in so many cases during treatment, and was so often followed by freedom from symptoms or "plus improvement" that we came to look on its appearance as a favorable sign. We noted also that when the reactions cleared up the majority of patients volunteered the statement that their general health had improved. When similar injections were made in 14 healthy volunteers, none had either reactions or malaise.

Our impression—supported by our figures as far as they go—is that patients treated by this method are relieved sooner, attend hospital less often, and have less disability than patients treated by other methods. In uncomplicated cases of fibrositis this method seems to relieve symptoms for longer periods than others familiar to us.

The case histories included in this report are typical of the patients treated in this country by the author.

CASE REPORTS

No. 1. P. F., an 84-year old white male, was examined in April 1952 with a history of a severe, burning pain in his left arm for the past six months. He showed fibrositic nodules in the biceps of the arm corresponding with the localized tenderness. Past treatments with cortisone, massage and diathermy were of no avail. The diagnosis was

rheumatic fibrositis of the left biceps. The patient received four injections, without reaction, and was discharged free of symptoms. At this writing (March 1954) he has so remained.

No. 2. M. F., a 40-year old white male, gave a history of pain in his back which increased with bad weather and on sitting. There was an area of tenderness in the region of the fourth and fifth lumbar vertebrae. The diagnosis was osteoarthritis of those vertebrae, and this was confirmed by x-ray. After 8 injections he was discharged and has remained free of symptoms.

No. 3. M. S., a 35-year old white female, was seen in October 1952 with a history of very severe pains in the cervical region for the past six months. All previous treatment failed to give relief. She presented areas of deepseated tenderness on both sides of the neck at the level of the third cervical vertebra, which was diagnosed as brachial neuritis. The patient was given six injections on each side, after which she was discharged free of symptoms, and has remained so to date.

No. 4. D. A., a 40-year old white male, was examined in November 1952 with a history of pain in his back and gluteal region for one year, with frequent recurrence. He presented areas of acute tenderness in the gluteal region and over the fourth and fifth lumbar and first sacral vertebrae. The Lasègue test was positive; ankle jerks were absent. Some sensory loss was found on the outer surface of the legs and soles. Diagnosed as rheumatic sciatica, the patient received two injections and was discharged. He has remained free of symptoms since.

No. 5. F. V., a 60-year old white female, was seen in November 1952, with a long history of severe pains in both knees as well as severe pains in her back. She was unable to walk and was bedridden. The knees were tender with considerable swelling in both. There was limited motion, especially on flexion. She had areas of tenderness over the fourth and fifth lumbar vertebrae. Osteoarthritis of both knees and of the fourth and fifth lumbar vertebrae was confirmed by x-ray. All four lesions were treated simultaneously, with six injections to each, after which she was discharged. She has remained free of symptoms to date and is able now to walk any desired distance.

No. 6. J. R., a 43-year old white male, was treated in January 1953 for distressing pain in his left knee for the past six years. For the past two years the pain never left him entirely. There were areas of tenderness in the gastrocnemius muscle, well localized, which were diagnosed as rheumatic fibrositis of that muscle, and the patient was given six injections. He was discharged and he has remained free of symptoms since.

No. 7. R. R., a 32-year old white male, was examined because of pain in his left elbow for six months. He showed an area of tenderness in the extensor carpi radialis longus of that side, consistently localized, which was diagnosed as a rheumatic fibrositis. The patient was given seven treat-

ments, after which he was discharged and he has remained free of symptoms to date.

No. 8. S. B., a 45-year old white male, presented himself in May 1953 with a history of pain in his left knee for the past six months. Eleven injections of cortisone brought no relief. He had pain and difficulty on walking. Flexion of that knee was limited. He had a warm joint, slightly swollen, with pain upon flexion. Diagnosed as osteoarthritis of the left knee, he received six injections and was discharged, remaining free of symptoms since.

No. 9. A. H., a 28-year old white female, was seen in May 1953 stating that for several weeks she has had pain in her left knee, especially when walking and in bad weather. She had a swollen knee, warm and tender on palpation, with slightly limited flexion. The diagnosis of osteoarthritis of the left knee was confirmed by x-ray and the patient was given one injection only. She insisted that she felt completely relieved and would take no more, but promised to return for monthly examinations. She has remained free of symptoms.

No. 10. I. D., a 38-year old white female, was treated in May 1953 for pain in her right arm extending to her shoulder and neck. She could not raise that arm and had difficulty at work. After a diagnosis of rheumatic fibrositis of the right deltoid was established, she received six treatments and was discharged free of symptoms with normal function restored.

COMMENTS

BASED on the writer's clinical experience, it is suggested that local chemotherapy of chronic arthritis and rheumatism with camphor and salicylates in oil is an effective treatment and an advance over existing methods. Emphasis is placed on the need for extreme accuracy in locating the rheumatic lesion before it is attacked. Not all osteoarthritic joints respond to this treatment in the same degree.

The Scott technic shortens disability time, the patient rarely requiring more than six treatments, all of which can be administered by the physician in his office. Only such patients who have too many lesions for office treatment, or who desire quicker results through massive treatments, need hospitalization or nursing home care.

Reactions consisted of malaise and pyrexia, in some cases, which passed in 24 to 48 hours. Pain, if any, can easily be controlled by simple measures. No infections or complications were noted. The usual aseptic precautions were followed.

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Thrombosis Due to Prolonged Sitting

Venous thrombosis of the legs occurs when there is stasis and obstruction of the veins of the lower extremities.

Among the more unusual causes of venous thrombosis is prolonged sitting, as recently pointed out by Homans.* He has described four patients who developed evidence of phlebothrombosis while sitting for long periods. Two patients had undertaken long airplane flights and the other two patients had taken long automobile rides.

It is probable that thrombosis occurs more frequently when one or both of the legs rest on some sort of support, causing injury to the venous endothelium. It is suggested that when one is sitting for long periods he should make movements of the toes, feet and lower legs to sustain the venous circulation. He should also get up and exercise when the opportunity avails itself.

Dr. Homans suggests that persons over fifty years of age should have this particularly in mind and that physicians should be alert to recognize the significance of lameness after long airplane flights or automobile trips.

If thrombophlebitis occurs, treatment consists of anticoagulants, bed rest, elevation and elastic bandaging of the legs.

* Homans, J.: Thrombosis of the Deep Leg Veins Due to Prolonged Sitting. New Eng. J. Med. 250:148, January 28, 1954.

Diamox® Effect on Intraocular Pressure*

Tonometric measurements made in nineteen patients who were given Diamox® in doses of 500 to 1000 mg. showed a marked decrease in the intraocular pressure in every instance. Following a single administration of Diamox® the pressure began to fall in from 60 to 90 minutes, reached a minimum in from three to five hours and returned to pretreatment levels in from eight to twelve hours. This reduction of the intraocular pressure could be repeated by subsequent doses.

This report by Becker is a preliminary one. He suggests that Diamox® may be useful preoperatively in glaucoma where there has been failure to respond to myotics and other measures. It may also be of help in tiding patients over acute inflammatory crises or traumatic episodes with secondary glaucoma.

Further investigation is being done to determine the value of continued Diamox® therapy for chronic glaucoma. Thus far no toxic effects on the eyes have been noted with Diamox®.

As yet it is not known whether Diamox® works by inhibiting the secretory mechanism of the eye or whether the fall in intraocular pressure is secondary to electrolyte changes on a systemic basis.

*Becker, B.: Effect of Oral Diamox® on Intraocular Pressure. Am. J. Ophth., January 1954.

LUIS E. VITERI, M.D.

JOHN M. McGEHEE, M.D.

BRADFORD W. LUNDBORG, M.D.

Mount Holly

Amebiasis in New Jersey*

Amebic dysentery with peritonitis and liver abscesses is reported in a lifelong resident of New Jersey.

AMEBIASIS in New Jersey is rarely recognized. According to a statistical survey made by the New Jersey Department of Health, a total of 87 cases of amebic dysentery have been reported in a period of nearly 5 years from 1949 to 1953. (Table 1.) These figures indicate that 49 cases were reported in 1949 of which 28 were from Hudson County. In the remaining 4 years, the total number of reported cases was 38. Only one previous case has been reported in Burlington County; in 1949. This is a report of a fatal case of amebiasis which is of interest because of its clinical features and because it will alert the profession to the possibility of this disease in our population.

It is likely that mild amebic infections occur more often than recognized or reported and there are certainly many unrecognized carriers of the disease. Bockus¹ states the the occurrence of amebiasis in the general population of the United States averages 5 to 10 per cent. During and following World War II and the Korean War, with the return of servicemen, we have in our midst an added source of amebic carriers. In New Jersey the influx of seasonal Puerto Rican labor during the summer months unquestionably has also increased the number of possible carriers.

THE report that follows relates a case of amebiasis occurring in a white young woman who apparently acquired the disease in New Jersey where she lived near the city of Burlington. She had never been outside of the country and rarely outside this state. The

TABLE 1. CASES OF AMEBIC DYSENTERY
IN NEW JERSEY BY COUNTY OF
RESIDENCE 1949-1953
(January-October, inclusive)

	1949	1950	1951	1952	1953 ¹
Atlantic County					2
Bergen County	1		4		4
Burlington County	1				
Camden County				1	
Cape May County			1		1
Cumberland County					
Essex County	1		1		
Gloucester County					
Hudson County	28	4		2	
Hunterdon County			1		
Mercer County				1	2
Middlesex County	1				
Monmouth County	4			2	
Morris County	7	2	1		3
Ocean County					
Passaic County	4		2		
Salem County					
Somerset County			1		
Sussex County					
Union County	1	3			
Warren County	1				
TOTALS	49	9	11	6	12

*From the Medical Department of the Burlington County Hospital, Mount Holly, N. J.

¹ Includes January-October, 1953.

source of infection may have been contaminated water from a well which she used for domestic purposes or by direct contact with her ex-soldier husband who had had an attack of dysentery while in the service. The specific etiology of that attack has not been definitely determined.

CASE REPORT

A young white housewife, 23 years of age, was admitted to the surgical service of the Burlington County Hospital with the possible diagnosis of acute cholecystitis or acute pancreatitis.

Her illness began on November 10, 1953, with severe pains in the right upper abdominal quadrant radiating to the back. This was associated with nausea, vomiting, anorexia and constipation. There had been no history of previous gastro-intestinal disorder, no weight loss or other systemic complaints.

She was married to a veteran who had served in Korea. She did her own housework; her immediate family including her children were in good health.

On admission her temperature was 99, pulse 90, respiration 20, blood pressure 130/90. The patient appeared in moderate distress from abdominal pain. Physical examination was negative except for findings in the abdomen. There she showed tenderness to palpation in the epigastrium above the umbilicus and under the right costal margin with moderate muscle spasm and suggestive rebound tenderness. There were no palpable masses; peristalsis was normal. There was slight distension of the upper abdomen. Pelvic and rectal examination showed nothing significant. Chest x-ray and flat plate of the abdomen were normal.

Laboratory findings: hemoglobin, 12.7 gms. per cent; white cell count 16,700, with a normal differential. The urinalysis was normal.

The clinical course was that of continued low grade fever and increasing abdominal distress and distention. Leucocytosis persisted and at times rose to 26,000 with 86 per cent neutrophils and one to two per cent eosinophiles. Fluid and electrolyte balance was maintained throughout her illness by the use of oral and intravenous fluids so that her blood chemistry including chlorides, carbon dioxide, and blood urea nitrogen remained within normal limits. Total protein and prothrombin times were normal.

One routine stool examination was reported positive for occult blood, but negative for ova or parasites. Following the administration of a double dose of dye (Priodax®) for a cholecystogram, the patient developed intractable bloody diarrhea and tenesmus which became extremely painful. These symptoms persisted in spite of opiates, Kaopectate®, and bismuth subcarbonate.

On the eleventh hospital day the patient was in severe abdominal distress in spite of heavy sedation. She was acutely ill, with hot, dry, flushed skin and an anxious facies. There were no findings of note in the neck or chest except for tachycardia

and an increased respiratory rate. The abdomen was prominent, especially about and below the umbilicus. There was suggestive flank dullness and marked tenderness throughout the abdomen, but more pronounced below the umbilicus. Peristalsis was markedly diminished. The rest of the physical examination was negative.

Proctoscopic examination the following day revealed the presence of ragged superficial ulcerations of the rectal mucosa with marked swelling and congestion. A serosanguinous fluid drained continually from the anus. Examination of a wet smear of that fluid showed motile amebae containing red blood cells. The diagnosis of intestinal amebiasis was thus established. Generalized peritonitis secondary to or coincidental with her amebiasis was thought to be present. Treatment with streptomycin and penicillin was started.

On the twelfth day Milibis® (bismuth glycolylarsanilate) through a gastric tube and intravenous Terramycin® were added. A flat plate of the abdomen now showed a shadow suggestive of fluid in the right flank and pelvis. In spite of specific and supportive treatment, the patient's condition deteriorated rapidly and she died on the sixteenth day of her illness.

In the last three days of life, the patient became disoriented and had a generalized convulsion on the day before her death. No clinical evidence of meningitis was detected.

A biopsy of the rectal mucosa at the time of the proctoscopy showed necrotizing amebic proctitis with many ameba present and necrotic debris. Post-mortem examination confined to the abdomen was permitted and a summary of the findings as given by Dr. John T. Bauer, who performed the autopsy is as follows:

At necropsy the body was well developed. The examination showed a widespread peritonitis resulting from disintegration of the wall of the large intestine which was the site of extensive amebic ulcerations and necrosis. Several small amebic abscesses were present in the liver. Amebae were noted throughout the peritoneal exudate as well as in that of the liver and in the walls of the large intestine. Death was caused by the infection beginning as an amebic dysentery and terminating as a combination of amebiasis and bacterial enteritis and peritonitis.

COMMENT

THIS was a case of acute fulminating amebiasis acquired in New Jersey in which the problem of early diagnosis was most difficult. All the findings pointed to one of the more common causes of acute pain in the upper abdomen such as cholecystitis, pancreatitis, or peptic ulcer. Coincidental onset of dysenteric symptoms following the administration of Priodax® further clouded the picture, for it

was thought that an acute gastro-intestinal allergy to that dye or a fulminating onset of ulcerative colitis were possibilities.

Proctoscopy and immediate microscopic examination of material taken from the ulcerated areas of the rectal mucosa finally gave the true diagnosis at a time when evidence of generalized peritonitis was already present. Because of the advanced stage of the disease, specific treatment with Milibis® and Terramycin® were of no avail.

The cause of the severe pain in the right upper quadrant is explained by the autopsy

findings in the liver. Generalized peritonitis from necrosis and perforation of amebic ulcers in the region of the cecum and appendix is a rather frequent complication according to Clark² and Strong.³

We feel that the diagnosis of amebiasis in our population depends on a high index of suspicion of this disease. Amebiasis should be considered as a less than remote possibility in the differential diagnosis of abdominal pain with or without peritonitis. Dysenteric symptoms are not necessarily present in acute amebiasis.

214 High Street

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2. Clark, H. C.: Distribution and Complications of Lesions Found in 186 Post-mortem Examinations.
3. Strong, R. P.: *Stitt's Diagnosis, Prevention and Treatment of Tropical Diseases*. Philadelphia, Blakiston, 1942.

Sprue*

Sprue is a chronic wasting disease classified among the deficiency states and responding to treatment with liver extract, folic acid, folinic acid and vitamin B₁₂, plus a high protein, high vitamin, low fat diet. As a result of treatment there is an improvement in the constitutional gastro-intestinal and hematologic signs and symptoms.

The term sprue includes the tropical and non-tropical forms although the latter is often called idiopathic steatorrhea. These syndromes are thought to be phases of one disease entity.

Recently Nickerson and Mathers have outlined the criteria for the diagnosis of the sprue syndrome:

1. Insidious onset, chronic course and rare spontaneous remission.
2. Inflammation of the mouth and tongue with or without papillary atrophy.
3. Gastro-intestinal disturbances such as indigestion, diarrhea or steatorrhea.
4. Recent loss of weight with increased weakness and prostration.
5. Free hydrochloric acid in the stomach in over ninety per cent of cases.
6. The presence of a macrocytic, hyperchromic anemia with a megaloblastic bone marrow.
7. A flat oral glucose tolerance curve.
8. Absence of neurologic manifestations.
9. Hyperpigmentation of the skin, especially face, arms and legs.
10. Inflammation and atrophy of the gastric and recto-sigmoid mucosa.

*Rodriguez-Molina, R.: Diagnosis of Sprue. *Ann. Int. Med.*, January 1954.

Obituaries • • •

DR. FRANK L. BIRD, SR.

Dr. Frank L. Bird, Sr. died on May 9 at the age of 62.

Dr. Bird received his medical degree in 1915 from New York University Medical School and interned at Bellevue Hospital, New York City. He served as a first lieutenant during World War I, and during World War II he headed the medical division of the Morris County Draft Board.

Dr. Bird had practiced medicine in Netcong since 1916.

DR. CHARLES D. GORDON

Dr. Charles D. Gordon of Mt. Arlington, died on May 15, at the age of 77.

Dr. Gordon was graduated from the College of Physicians and Surgeons, Baltimore in 1910. He served as medical inspector of Jefferson Township and Mt. Arlington schools for several years, and was on the Hopatcong Borough Board of Health. He was known for over forty years as the "horse and buggy" doctor. He retired in 1951.

Dr. Gordon was an honorary member of the Morris County Medical Society.

DR. HARRISON S. MARTLAND*

Dr. Harrison S. Martland died unexpectedly at his home on May 1.

Dr. Martland was born in Newark in 1883. He received his medical degree from the College of Physicians and Surgeons of Columbia University in 1905. After interning at Newark City Hospital, he went to Russell Page Institute of Pathology as assistant pathologist, which post he held for two years. From 1909 to 1953 he was pathologist at Newark City Hospital, and in 1933 he became associate professor of forensic medicine at New York University.

In 1925 Dr. Martland was named county physician. He established the medical examiner system in Essex County and was appointed chief medical examiner in 1927. In 1952 he was appointed for his sixth consecutive five-year term.

Dr. Martland was a member of the American Society of Clinical Pathologists and the American Society of Immunologists and Serologists. He had been pathologist at St. Mary's Hospital,* Orange, and consulting pathologist at the New Jersey State Hospital at Greystone Park, Essex County Hospital at Cedar Grove, the State Village for Epileptics at Skillman, and several Newark hospitals. During World War I, Dr. Martland was a lieutenant colonel in the medical corps and was in charge of a hospital at Vichy, France. For a short time he was consulting pathologist at Vanderbilt Hospital in Paris.

County Society Reports • • •

Camden

President Edwin R. Ristine opened the annual meeting of the *Camden County Medical Society* on May 4.

Dr. Robert L. Reherrmann was introduced to the Society after taking the membership oath.

Dr. Max Frantz read a memoir on the passing of Dr. Hyman I. Goldstein. Dr. Ristine then called for a silent memorial honoring those members who passed away during the past year; namely, Drs. Robert S. Gamon, Claude B. Phillips, Edgar A. Farrell, Robert E. Imhoff, Maurice Baker and Hyman I. Goldstein.

Reports of the various committees were read and received. The Public Health Committee was especially commended for its successful work on the Public Health Forum.

Dr. Ristine presented a farewell address which

proved so inspirational that a motion was passed for his remarks to be submitted to the state journal for publication.

The following officers for 1954-55 were unanimously elected: *President*, Dr. Harold K. Eynon; *President-Elect*, Dr. A. G. Pratt; *Vice-President*, Dr. E. A. Y. Schellenger; *Secretary*, Dr. Frank J. Hughes; *Treasurer*, Dr. Robert N. Bowen; *Historian*, Dr. Helen F. Schrack; *Reporter*, Dr. Frederick W. Durham; *Trustee*, Dr. James S. Shipman; and *Censor*, Dr. Edwin R. Ristine.

The Society was reminded of the annual outing to be held at Woodcrest Country Club on June 2.

FREDERICK W. DURHAM, M.D.

Reporter

*For editorial comment on the death of Dr. Martland, see page 301 of this JOURNAL.

Gloucester

Dr. Ralph L. Moore presided at the regular meeting of the *Gloucester County Medical Society* held at the Woodbury Country Club on May 20.

Dr. Michael G. Wohl, clinical professor of Medicine at Temple University, spoke on current methods of diagnosis and treatment of thyroid disease.

The society voted to send telegrams to our representatives in Congress voicing our disapproval of being included in Social Security. Several members reported on the recent convention in Atlantic City.

It was decided to send a letter to Dr. Henry B. Decker commending him on his fine administration. After much discussion it was decided to leave the Selective Service Committee as it was unless someone resigned.

The following officers were then elected unanimously: *President*, Dr. John J. Laurusonis, Gibbstown; *Vice-President*, Dr. William T. Beall, Woodbury; *Secretary*, Dr. Dorothy M. Rogers, Woodbury; *Treasurer*, Dr. Francis M. Brower, Woodbury; *Historian*, Dr. Dorothy M. Rogers, Woodbury; *Reporter*, Dr. Louis K. Collins, Glassboro.

Being roundly applauded for his fine work of the year, the retiring president, Dr. Moore thanked his committees and turned the chair over to Dr. Laurusonis. The latter outlined his program for the coming year and appointed the various committees.

LOUIS K. COLLINS, M.D.

Reporter

Middlesex

The regular monthly meeting of the *Middlesex County Medical Society* was held at the Roosevelt Hospital, Metuchen, on May 12 with Dr. Malcolm M. Dunham, president, presiding.

The following were elected to regular from associate membership; Drs. Sara Ann Bunin, Howard Joselson, Perth Amboy; Thomas M. Heslin, New Brunswick and T. Lloyd Kolbay, Metuchen.

Dr. Charles H. Evans of the Orange Memorial Hospital, Orange, gave an interesting talk illustrated with slides on intestinal obstruction in infants and the newborn.

A letter from Dr. Lavern C. Bassett was read, expressing his regret that because of illness he would be unable to continue as vice-president of the Society.

A letter containing a new wage scale has been sent to the members of the Middlesex County Welfare Board.

A motion was passed to instruct the delegates to the State Society's annual convention May 17-21, to accept the resolution of the Special Committee on Division of Surgical Fees.

A motion was passed to send a letter of acknowledgment and sympathetic interest to the Mental Health Association of Middlesex County.

All members of the Middlesex County Medical Society are to be assessed \$10.00 for the Christmas party to be held next December. Each member who attends will be assessed an additional \$5.00.

IVAN B. SMITH, M.D.

Reporter

Morris

The *Morris County Medical Society* met at the Springbrook Country Club on June 17.

The Pfizer Company was host to the Medical Society and sponsored a golf tournament in the afternoon and dinner in the evening. The golf tournament was won by Dr. Richard Graft of Madison, a novice upon whom a gift of professional golfing calibre descended for a day.

Dr. Jack L. Voss presided at the annual business meeting which followed the dinner. He introduced Dr. Vincent Butler, President-Elect, and Dr. Lewis Fritts, First Vice-President of the state society. Dr. Ralph Buchanan and Dr. Jesse McCall were other visitors from outside the county confines introduced to the membership.

A new slate of officers was elected for the next year headed by Dr. Nicholas Bertha of Wharton, *President*, and Dr. Harold Hatch of Shonghum, *Vice-President*.

ALBERT ABRAHAM, M.D.

Reporter

Passaic

The annual meeting of the *Passaic County Medical Society* was held on May 25 at the Medical Society Building. Dr. Floyd Fortuin, president, presided.

Dr. Donald D. Dingman, of Paterson, was elected to active membership. The following physicians were elected to associate membership: Drs. Charles A. Priviteri, Stanley J. Gusciara and Robert J. Waldron of Passaic; and Thomas G. Petrick of West Paterson.

The following officers for 1954-1955 were unanimously elected: *President*, Dr. Leopold E. Thron; *First Vice-President*, Dr. Thomas F. Reilly; *Second Vice-President*, Dr. Joseph R. Jehl; *Secretary*, Dr. Abraham Shulman; *Treasurer*, Dr. Theodore K. Graham; *Assistant Treasurer*, Dr. Francis B. Brogan; *Board of Censors* (3 years), Dr. Floyd Fortuin; *Building Trustees* (3 years), Drs. Samuel J. Della Penna, William A. Dwyer, R. R. Goldenberg, and Fred Vosburgh.

Dr. Fortuin reminded members that Social Security legislation was approaching a final vote in Congress, and asked all to inform their Congressmen of their views on inclusion of physicians under Social Security.

Dr. Fortuin then turned the meeting over to Dr. James P. Morrill, Jr., who introduced Dr. Philip M. Stimson. Dr. Stimson spoke on "Some Newer Aspects of Poliomyelitis." Following his address, refreshments were served.

DAVID B. LEVINE, M.D.

Reporter

Salem

The annual shad dinner of the *Salem County Medical Society* was held on May 22 at the Salem Country Club. Nineteen members and their wives attended, along with guests who had been speakers at previous meetings. Among the guests were Dr. and Mrs. Katzenstein of Wilmington, Delaware and Mr. and Mrs. Dayton of Plainfield. Our main speaker was Dr. Kroughman of the University of Pennsylvania Graduate School of Anthropology, who gave a very entertaining and informative talk on his work with the identification of bones for the F. B. I.

and various police departments throughout the country.

Dr. Charles B. Norton, the incoming president, outlined his program for the coming year.

The next meeting of the Salem County Medical Society will be on September 17, 1954.

FORD C. SPANGLER, M.D.

Reporter

Radiological Society of New Jersey

At the annual meeting of the *Radiological Society of New Jersey* on May 19, the following officers were elected for the year 1954-55: *President*, Dr. Nicholas G. Demy; *Vice-President*, Dr. Salomon Silvera; *Secretary*, Dr. Carye-Belle Henle (195 N. 7 Street, Newark); and *Treasurer*, Dr. Leonard S. Ellenbogen.

The Society meets in Atlantic City at the time of the annual meeting of the state medical society, and in Newark in November.

S. SILVERA, M.D.

Woman's Auxiliary Report • • •

Essex

Mrs. Stuart Z. Hawkes, President of the *Woman's Auxiliary to the Essex County Medical Society*, held her final Executive Board Meeting at the Metropolitan Club, New York. Thirty-one members were her guests at the luncheon which preceded the meeting.

In terminating her official duties as president, Mrs. Hawkes presided at the meeting held May 10, at Mayfair Farms, West Orange.

Following lunch, Mrs. Charles O'Neill, program chairman, presented William Hahn, M.D., president of the Essex County Medical Society; and Jerome Kaufman, M.D., incoming president-elect of the Society. Frank Forte, M.D., the incoming president, was absent due to illness. Dr. Hahn spoke on the necessity of continuing good doctor-patient relationship and stated our philanthropies were indeed all worthy projects. He also commended Mrs. Samuel H. Jesserun, for the work she has done on medical history. Mrs. Frank Forte, State Auxiliary President reported the year's donation from the state to the American Medical Education Foundation was over \$2,000, with Essex County in the lead by our contribution of \$1,065.07.

Memorial services were held by Mrs. Anthony Ambrose for the following: Mrs. Wells P. Eagleton, Mrs. Julius Sobin and Mrs. John Haggerty.

No annual committee reports were read. These were compiled in booklet form and distributed to all members present to peruse at their leisure.

After the presentation of the past-president's pin to Mrs. Hawkes by the immediate past-president, Mrs. Jerome Kaufman, Mrs. Jesse Glazier, parliamentarian, greeted and declared the following officers duly elected and installed: *President*, Mrs. Philip D'Ambola of Harrison, who stressed "fund raising" and the continued cooperation of all members in her acceptance speech; *President-Elect*, Mrs. Ralph R. Autorino, Montclair; *First Vice-President*, Mrs. Harry E. DiGiacomo, Newark; *Second Vice-President*, Mrs. Thomas Messina, East Orange; *Recording Secretary*, Mrs. William Miningham, Jr., Newark; *Treasurer*, Mrs. Paul Aszody, Newark; *Financial Secretary*, Mrs. Don A. Epler, East Orange; and two Directors, Mrs. Anthony J. Biunno and Mrs. George Parell of Newark.

MRS. HARRY E. DIGIACOMO

Chairman, Press and Publicity

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Thoracic Surgery. Second Edition. By Richard H. Sweet, M.D., Associate Clinical Professor of Surgery, Harvard University Medical School. Illustrations by Jorge Rodriguez Arroyo, M.D. Pp. 381. Philadelphia, W. B. Saunders Co., 1954. (\$10.00)

In a young specialty like thoracic surgery, four years is not too soon for a second edition to appear. It was expected that many changes would be found in this edition. In general, this has not been the case. However, the few changes that have been described have justified its publication.

The print in this edition is larger and easier to read. The first edition was reviewed in the April 1951 issue of this JOURNAL. The second edition is the same as the first with very few changes in the illustrations and some additions in descriptions of procedures.

In Chapter 2, "General Technical Considerations," there is a portion devoted to the suture materials used in thoracic surgery as well as a table showing the various sutures and needles. For the operating nursing staff there is an outline of instrument lay-outs for chest operations. New instruments such as Finochietto retractors and special instruments for general use are described. The instruments for surgery of the great vessels, particularly for mitral and pulmonary stenosis and vascular anastomosis, have been increased from 11 to 23.

In Chapter 4, lucite ball plombage is described as well as the paraffin procedure (practically no longer used).

In Chapter 6, in the treatment of carcinoma of the lung, a lobectomy is advocated for poor risk patients.

In Chapter 7, Dr. Sweet advocates a sternal splitting incision instead of an antero-lateral incision for the operation of pericardectomy.

With all the publicity and numerous publications on cardiac surgery, it was interesting to find that in 1954 Dr. Sweet repeats what he said in 1950: "There is no branch of thoracic surgery which is more unsettled at the present time than that of the heart. New technics are being tried and older methods are being modified in an effort to overcome the crippling effects of certain cardiac disorders." Closure of septal defects is still an unestablished procedure. Under "Acquired Disorders of the Heart," mitral valvulotomy is described for the first time as one of the established procedures, whereas in the first edition it was described under unestablished procedures.

In the second edition the Brock procedure of a pulmonary valvulotomy is described as an established operation. Operations to improve the vascularity of the myocardium are still listed as un-

established procedures. The operation of extracardiac shunt to relieve the pulmonary congestion of mitral stenosis which Dr. Sweet first proposed in this edition has received less emphasis. Very few thoracic surgeons have adopted it.

In considering esophageal surgery, a description of the modification of the Heller operation for the relief of achalasia is included. Otherwise surgery of the esophagus remains essentially the same. Berman tubes are not mentioned although the author has found them valuable in very poor risks or in cases where hope of a "cancer cure" is not possible.

The rapid advances in thoracic surgery justify this new volume. It should be well received both here and abroad.

HENRY A. BRODKIN, M.D.

Music Therapy. Edited by Edward Podolsky, M.D. Pp. 335. New York, The Philosophical Library, 1954. (\$6.00)

With scissors and paste, Dr. Podolsky has assembled a mishmash of papers on music therapy. Some papers are good, some are bad, and some are so-so. There is no effort to integrate the papers, to balance them in proportion to their relative importance, to interpret or to edit. If you search, you will find some solid articles on music therapy: papers by the Misses Brown, Preston and Price, and by Drs. Altshuler, Reese, Simon and Pickrell. All these are useful. You will also find some dreadful time wasters, chock full of cliches. Consider, for instance, such gems of the obvious as: "all of us have our moments of anxiety"; "you can moderate your tendencies to anger by replacing bad feelings with good feelings" (they charge \$6 for this book, remember); "the feeling of being down in the dumps is an unpleasant one"; "the nervous type of headache afflicts many"; and (this is my favorite): "grief is an experience that all of us have to experience."

Some of the articles tell you exactly what to expect from music therapy, what pieces to play and how to play them. Other chapters tell you nothing. Several bore you with tediously detailed case reports. A rare athetosis, for instance, is reported in gruesome but useless detail for 28 solid pages, while much more common conditions are given a once-over lightly. A few dramatic cures by music are recited. Some of the chapters are elementary, pitched at the high school level, dealing with the ABC's of psychology.

The trouble with this whole pastiche is that the papers were written at different times, by different authors, to different audiences, for different pur-

poses. The editor does not even date the articles, so you don't know if you are reading something that was written last week or something that was thought up during the McKinley administration. There is a lot of duplication because the editor did not edit. The author of one chapter quotes the author of another, often repeating what the latter has said elsewhere in the book. A nonphysician prescribes for headache and another for hypertension. Another layman (this one living in New Jersey) even says that music has "proved of great value in helping the psychopathic personality face his environment in a realistic manner."

The time is now ripe for a practical manual of music therapy. But to get up a useful handbook requires an editor who will edit; one who will weave the various articles together into a unified, nonrepetitive pattern. This one does not even have an index, so the reader who knows that there is a good idea buried somewhere in the book (and there *are*) is completely baffled when he tries to track it down.

HENRY A. DAVIDSON, M.D.

Planning Guide for Radiologic Installations. By The Committee on Planning of Radiologic Installations of the Commission on Public Relations, American College of Radiology, Wendell G. Scott, M.D., chairman. 336 pages. Chicago, Year Book Publishers, Inc., 1953. (\$8.00)

As stated by Dr. Scott in the preface, the preparation of this book was a "joint endeavor by radiologists, representatives of the companies manufacturing x-ray equipment and film, of Federal health agencies, of The American Hospital Association and the American Institute of Architects." Its purpose is to supply an authentic source of information concerning radiologic installations. All of the contributors have the highest qualifications and write with a background of great experience.

The chapters cover every phase of radiologic installations from private office to large hospital department. An attempt is made to provide in detail for all the functions in a radiology department from the moment the patient enters the waiting room to the final disposition of films and records. There are chapters on special phases of diagnostic roentgenology and also radio-isotope laboratory design, radium handling and radiation protection.

Good planning in a radiology department or office is of vital importance for the patient's and physician's comfort and protection and provides the most efficient service. This guide is an invaluable help in achieving these objectives.

JULES H. BROMBERG, M.D.

Children for the Childless. By Morris Fishbein, M.D., Pp. 223. Garden City, N. Y., Doubleday & Co., 1954. (\$2.95)

Doctor Fishbein should be congratulated for editing a book of this type. Several very prominent authors, including I. C. Rubin of New York, Nicholson J. Eastman of Baltimore, and J. P. Greenhill of

Chicago, have contributed chapters to this publication.

At least three groups will benefit by this book. Since it is written for laymen, couples whose marriages have been barren for a number of years will derive a wealth of information, easy to understand and plainly written, to guide them in going about sterility investigation and adoption. Secondly, the book describes the most recent research on conception, sterility, and adoption; it will therefore serve the physician who desires more information about this comparatively new specialty. Thirdly, numerous welfare agencies which deal with problems of sterility and adoption will do well in acquainting their case-workers with the facts which this book offers.

It is debatable whether chapter 1, "On Being a Parent Today," written by Sidonie M. Gruenberg, properly fits into such a publication. It describes the problems of becoming parents, problems which are inherent to both fertile and sterile couples.

Morris Fishbein himself wrote the second chapter, "Physical Aspects of Fertility and Sterility" in which the anatomic and physiologic facts of the sex organs and mating are understandably depicted.

The third chapter, "Psychosomatic Aspects in Fertility and Sterility" describes a comparatively new, although indispensable, topic with which the sterility investigator has to concern himself. Dr. Edward Weiss explains in a masterly fashion how certain premarital repressions, particularly on the part of the woman may bring about a "functional sterility" after marriage. There will always be about 10 per cent of "unexplained sterile matings," and some of these may be caused by psychosomatic manifestations. The questionnaire reproduced in this chapter has been used by this reviewer to good advantage and the answers given by intelligent patients have helped to eliminate certain obsessions and guilt feelings.

The section devoted to human sterility has been aptly written by I. C. Rubin. It offers the steps in investigating sterile couples and the treatment suggested for the different causes of barrenness. N. J. Eastman publishes interesting statistics on human fertility, and his experiences collected while he was Professor of Gynecology and Obstetrics at the American University in Peiping, China, provide fascinating reading material. In this chapter the factors which affect fecundity are skillfully put together and clarify many problems with which students of sociology or demographers are confronted in the post-war period.

Doctor Greenhill's contribution on artificial insemination is well-written and instructive. The final chapters on adoption and heredity likewise report many interesting facts.

It is suggested that in future editions a certain amount of overlapping and repetition be eliminated. However, these minor faults do not detract from the immense value of this book. Physicians who frequently deal with sterility patients would profit by having several copies on hand which they could loan to their patients. They could thus save a great deal of the time usually required in explaining the cause of sterility to wife and husband. It can be warmly recommended to the thousands of un-

fortunate couples to whom nature has denied progeny and who have become the victims of unscrupulous people by being literally "milked" of hundreds of dollars every year. If the book finds its way into the homes of those who are eager to secure a child, either by their own creation or through adoption, the small price will be repaid a hundred-fold.

WERNER STEINBERG, M.D.

Mayo Clinic Diet Manual. By the Committee on Dietetics of the Mayo Clinic. 2d ed. Pp. 247. Philadelphia, W. B. Saunders Company, 1954. (\$5.50)

The purpose of this manual is to provide information on food values when they are needed in a hurry. The average practicing physician would not be impressed with its contents. For him it would mean a lengthy explanation to his patient on the data provided and he would find himself in a maze of complicated figures.

For the student in nutrition, dietitian, or home economist this can be a valuable manual because it is often necessary for them to calculate quickly the value of an individual's diet. The tables in this manual can be helpful in constructing a sample menu for various diseases.

The second edition is not an improvement over the first edition to any appreciable degree. There are many books and publications on the market which give similar data on food values in the form of quick and easy references.

This manual is limited both in its content and its value since it cannot be used by the laymen or the busy practicing physician.

S. WILLIAM KALB, M.D.

Pediatric Gynecology: With Sections on Urology and Proctology. By Goodrich C. Schauffler, M.D., Assistant Clinical Professor of Obstetrics and Gynecology, University of Oregon Medical School, 3d. ed. Pp. 318. Chicago, The Year Book Publishers, Inc., 1953. (\$7.50)

In reading this excellent book and considering our present-day "age of specialization," the title should more appropriately have been, "Gynecological Problems in Pediatrics." This is a book primarily for practicing pediatricians though written by a gynecologist. There is much to be learned, however, by the gynecologist, surgeon, proctologist, and also the general practitioner who may first see many of the conditions described.

The author's purpose is to introduce a field which has been dealt with rather hazily in the past. Time and again he warns that we must carefully differentiate between examination and treatment in the adult and the child, and not too casually transfer our experience from one to the other. There are many differences not only in the anatomy, but also in symptoms, signs, and even our approach to a simple examination.

The book is well divided. After a brief but excellent summary of psychologic considerations there is a good summary of methods of examination. As many of us know, it is not usually easy to examine

properly the genitalia of a seven-year old. Ordinarily, superficial external inspection, a finger in the rectum, and the exam is finished, the child yowling, and the mystery of diagnosis still there. These pitfalls are discussed and a thorough examination outlined.

Thereafter, individual chapters discuss each organ. There is special emphasis, however, on diagnosis and treatment of vaginitis, which is a frequent "headache." A sensible but rather brief section is devoted to adolescent disorders. Concise chapters are then presented on surgical aspects, urologic disorders, and proctologic disorders.

This is primarily a "clinical" book, which will be welcomed by many who have been looking for such material in one easy volume. It seems practical, although mere studying it will not enable the reader to perform the examinations without patience and practice.

STANLEY J. GOODMAN, M.D.

Review of Physiological Chemistry. By Harold A. Harper, Ph.D., Professor of Biochemistry, University of San Francisco. Pp. 328. Los Altos, Calif., Lange Medical Publications, 1953. (\$4.00)

Biochemistry, for most physicians, is a subject studied diligently in medical school and then more or less forgotten during the pursuit of clinical subjects. Dr. Harper's book, intended as a supplement to standard texts in biochemistry for the student in such courses, is a meaty scientific volume. Its twenty-two chapters cover modern biochemistry completely and in detail. Innumerable chemical formulae, charts and diagrams amply illustrate the text.

The first chapter deals with the general principles of biochemistry. It defines electrolytic dissociation, acids and bases, the concept of pH and similar subjects. The Donnan equilibrium is described, as well as colloidal states, surface tension and viscosity.

The second chapter describes carbohydrates in great detail; particular attention is given to the structural relations of the carbohydrates and definitions of the various types such as aldoses and ketoses.

A similar complete discussion is then given of the fats and proteins followed by descriptions of nucleic acid metabolism, liver function, kidney, water and mineral metabolism, the hormones, etc. Each topic is discussed in detail and current concepts presented. For example, the Krebs cycle is made as clear as possible, considering its complexity.

This book is by no means easy to read. It is not intended as a smooth road to biochemistry. For physicians interested in a compact, detailed, and up-to-date presentation it will serve as a useful reference.

It is primarily concerned with normal and abnormal metabolism and is in no way a book of therapeutics. However, because of its completeness it should fill the need for a brief inexpensive compendium of biochemistry.

R. D. GOODMAN, M.D.

TUBERCULOSIS *Abstracts*

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Current Trends in Tuberculosis

By Mary Dempsey, Statistician, National Tuberculosis Association, February 3, 1954.

Probably more persons are under treatment for tuberculosis today than was ever before the case in this country. Most people are aware that the gradual decline in tuberculosis mortality has increased precipitately for the past few years; others know that the incidence of the disease is declining slowly; very few are conscious, however, that large and even increasing numbers of patients are coming under treatment.

Two factors help to account for the high prevalence of tuberculosis today—or rather for the high prevalence of KNOWN cases. Since 1945, tuberculosis case-finding activities have been carried on in many places and on a large scale. As a result a higher proportion of existing cases has been found than was previously known. The great majority (we hope) are receiving treatment.

Primarily as a result of new kinds of treatment patients who would have died young now live until their disease is arrested. This fact with the augmented case finding has resulted in more patients under treatment than were previously known, even though morbidity and mortality are declining.

A sharp distinction should be made between incidence and prevalence. The annual incidence is the number of new cases which develop in a year; the prevalence of tuberculosis is the number of existing cases on any given date.

Slow decline in new reported cases.—The fact that today more patients with active tuberculosis are under care than ever before does not mean that there is any increase in the incidence. The number of *new* cases is declining slowly, while the

total of all *known* cases is showing a tendency to increase. During the period 1946-1948 mass community x-ray surveys were successful in locating a backlog of cases, many of which should have been reported years earlier; as a result, the number of new cases reported showed a definite increase. At that time, this advance was erroneously thought to represent a true rise in tuberculosis morbidity. Subsequent developments have confirmed the opinion that no actual increase had occurred.

The number of new cases reported has declined appreciably during the last two years. In 1952 the total number of new cases reported to health departments in the United States was 109,837, of which 85,607 were active or probably active.

Large numbers of cases are still unreported; but each year sees many cases reported which should have been known to health authorities years before. Probably fewer inactive cases will be reported in the future, now that agreement has been reached on the definition of a reportable case.

Decline in mortality.—Fifty years ago the tuberculosis death rate was 188 per 100,000 while today it is less than one-tenth that figure. Every agency and individual who has been interested in tuberculosis control shares in the credit for this sensational drop in mortality.

A second achievement rarely noted is the advancing age at death for those who died of tuberculosis. In 1924, the median age at death was 33.3 while in 1950 it was 49.7. Tuberculosis is rapidly becoming a disease of older men. Today half of all deaths from tuberculosis in this country are those of men 40 years of age and older.

The accelerated decline in tuberculosis mortality which has occurred recently is usually attrib-

uted to new forms of treatment. The use of excisional surgery and antimicrobial drugs have kept alive many who would otherwise have died from this disease. Some of them remain sputum-positive and the necessity for isolation is as urgent as ever. Thus, with a greatly lowered death rate from tuberculosis we have more patients under treatment than ever before.

Home care programs.—According to reports from widely separated states, the introduction of isoniazid has led to the establishment of home care programs for the tuberculous. We are told—rather indefinitely, it is true—that large numbers of patients are being treated at home with the result that vacant beds are reported from communities which once had long waiting lists. Is this a transitory occurrence? Or is it the beginning of a sustained trend toward home treatment? Today, no one seems able to answer these questions.

At this stage of development, organized home care programs under close supervision by clinics and public health nurses appear to offer a partial solution of the involved tuberculosis problem in large cities where health administration is highly organized. It is difficult to understand why such a program is needed or can prove successful in smaller communities which lack adequate clinic and public health nursing facilities.

Only time will tell how well the carefully supervised home care programs turn out. If the suspicion proves warranted that some patients are receiving drug treatment at home or at work with inadequate or no supervision, one does not know what to expect in the near future. Will these patients improve under such treatment? Or will they seek admission to tuberculosis hospitals in the near future? Are they spreading the disease? No one knows what is happening now nor do they know what will come next.

Cost of tuberculosis.—The excessive cost of the tuberculosis problem has seldom been faced by law-making bodies or health organizations. It is conservatively estimated that each case costs ap-

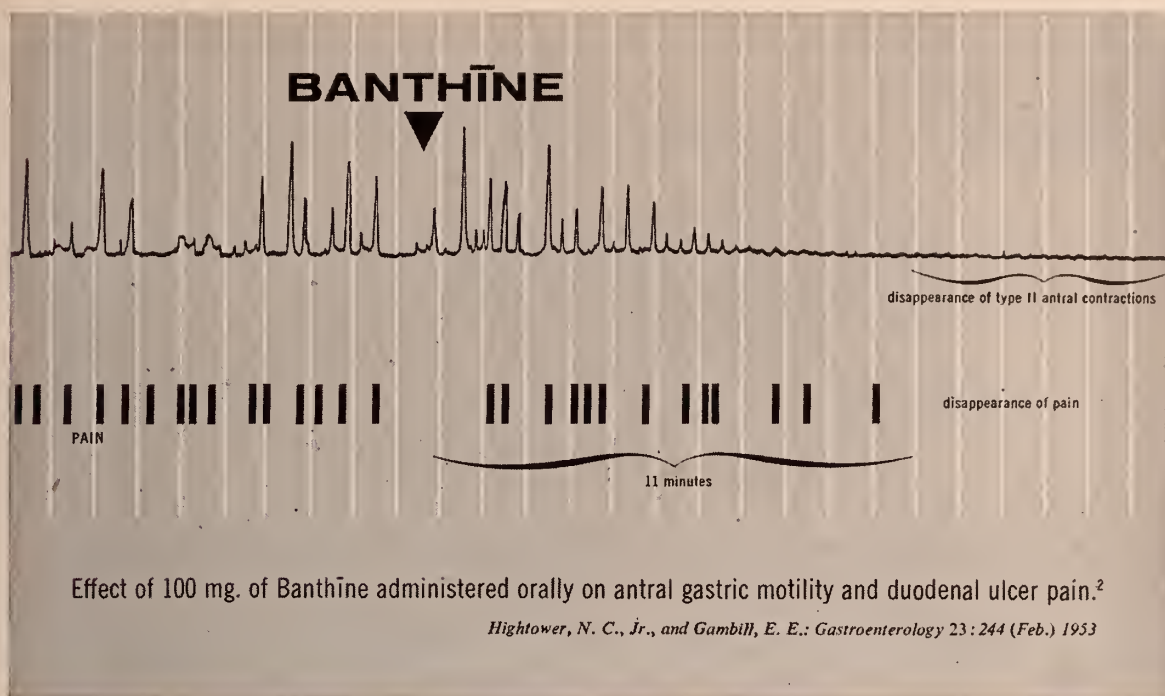
proximately \$15,000; this amount includes cost of medical and nursing care, health education, case finding, rehabilitation, loss of the patient's wages, compensation, pensions, and relief payments to the patient's family while he is incapacitated. If the loss of patient's productive capacity and potential future earning power were included, the cost per case would be doubled.

One reason for the high estimated cost per case is the tendency toward relapse or reactivation which is an outstanding characteristic of this chronic disease. The average cost of maintaining a patient during his second or third hospital stay is from two to four times the cost of maintenance during his first stay. Many patients, especially those whose disease was not far advanced, have been treated by bed rest only during their first stay. When they return to the hospital, surgical treatment is often considered necessary. Some patients who have refused to accept surgical intervention will agree to it after readmission.

Cause and effect of poverty.—Few of us realize that tuberculosis is both a cause and an effect of indigency. It is simple to grasp the fact that poverty lowers resistance so that the disease spreads rapidly when families live on an inadequate or unbalanced diet, are crowded into insanitary homes, can obtain little education. But we do not always stop to think how directly tuberculosis leads to poverty in families where it did not previously exist. A recent study of a sizable group of patients pointed out that less than two per cent of the patients' families were relief recipients at the time of diagnosis; upon being admitted to hospitals a few months later, 16 per cent were receiving public assistance. At the time of hospital discharge 50 per cent of the families of these same patients were on relief.

Estimates of the overall annual loss from tuberculosis in this country run to as much as six hundred million dollars. Even this astronomical sum does not include the cost of hospital construction, depreciation of hospital buildings, or the training of professional personnel.

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Ruffin, J. M.; Texer, E. C., Jr.; Carter, D. D., and Baylin, G. J.: J.A.M.A. 153:1159 (Nov. 28) 1953.

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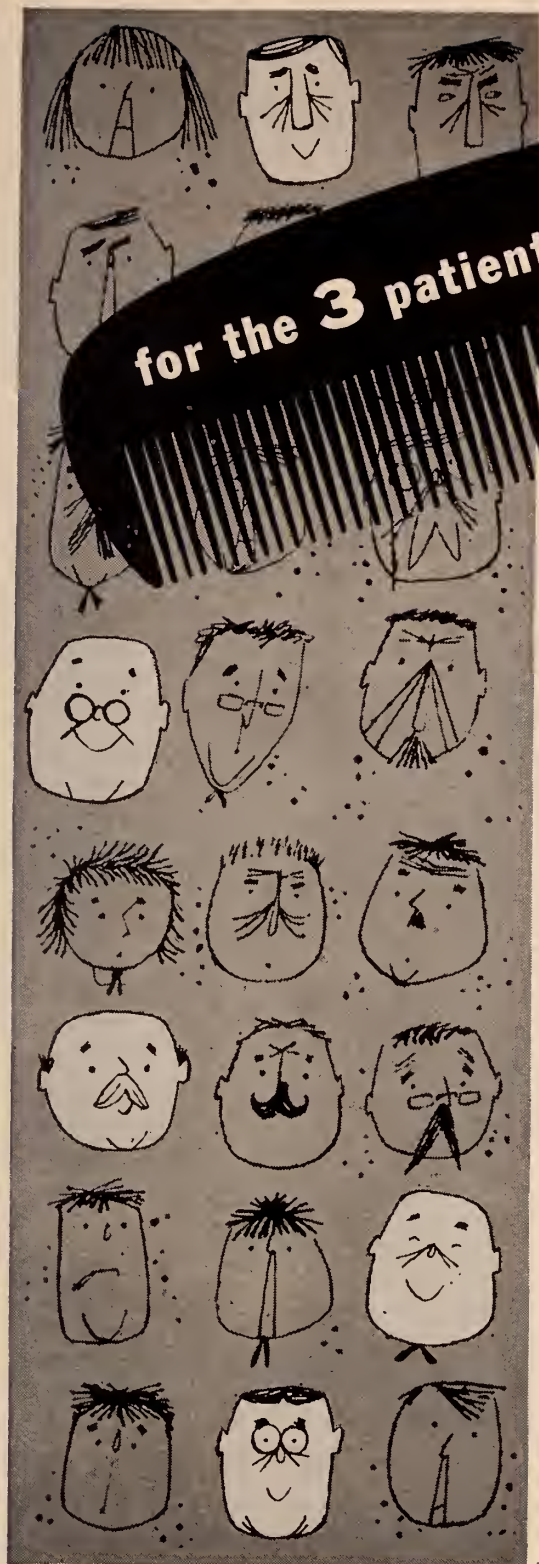
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1. Slepian, A. H. (1952), Arch. Dermat. & Syph., 65:228, February. 2. Slinger, W. N. and Hubbard, D. M. (1951), *ibid.*, 64:41, July. 3. Sauer, G. C. (1952), J. Missouri M. A., 49:911, November.

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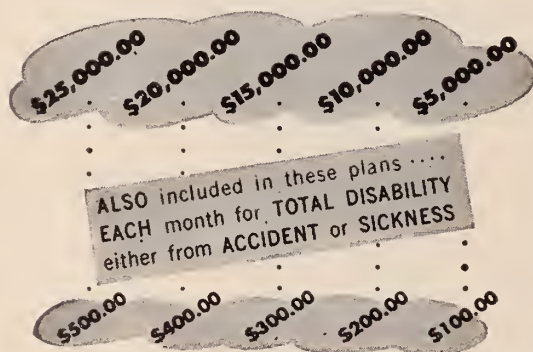
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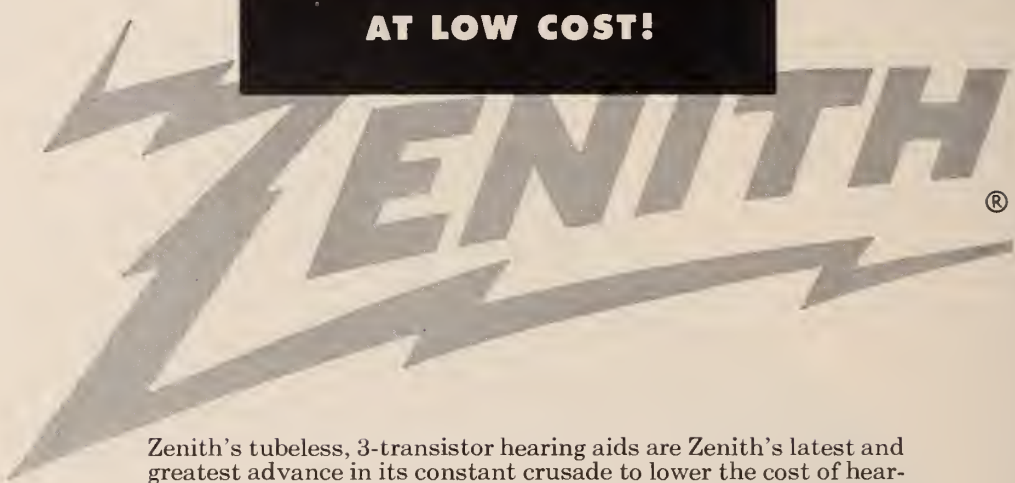
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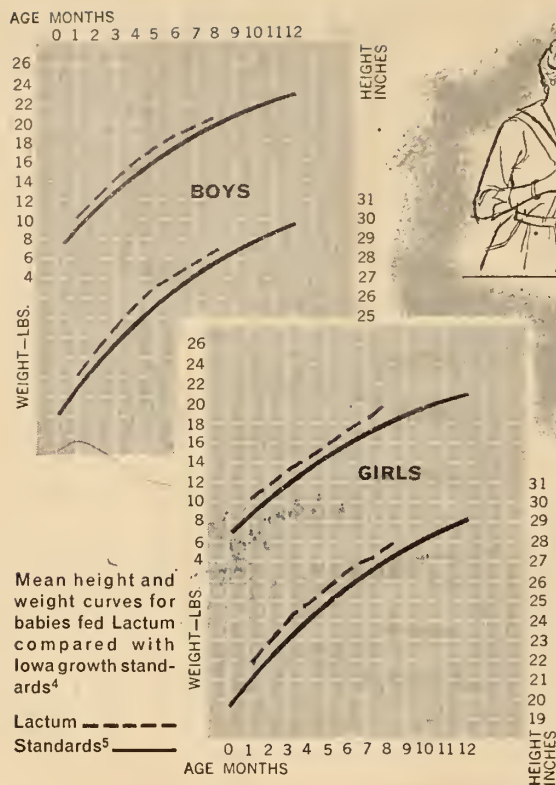


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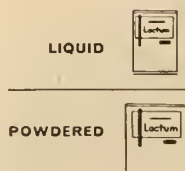
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(1) Jeans, P. C.: In A.M.A. Handbook of Nutrition, Ed. 2, Philadelphia, Blakiston, 1951, p. 275. (2) Albanese, A. A.: *Pediatr.* 8: 455, 1951. (3) Holt, L. E., Jr., and McIntosh, R.: In *Holt Pediatrics*, Ed. 12, New York, Appleton-Century-Crofts, Inc., 1953, pp. 175-178. (4) Frost, I. H., and Jackson, R. L.: *J. Pediatr.* 39: 585, 1951. (5) Jackson, R. L., and Kelly, H. G.: *J. Pediatr.* 27: 215, 1945.

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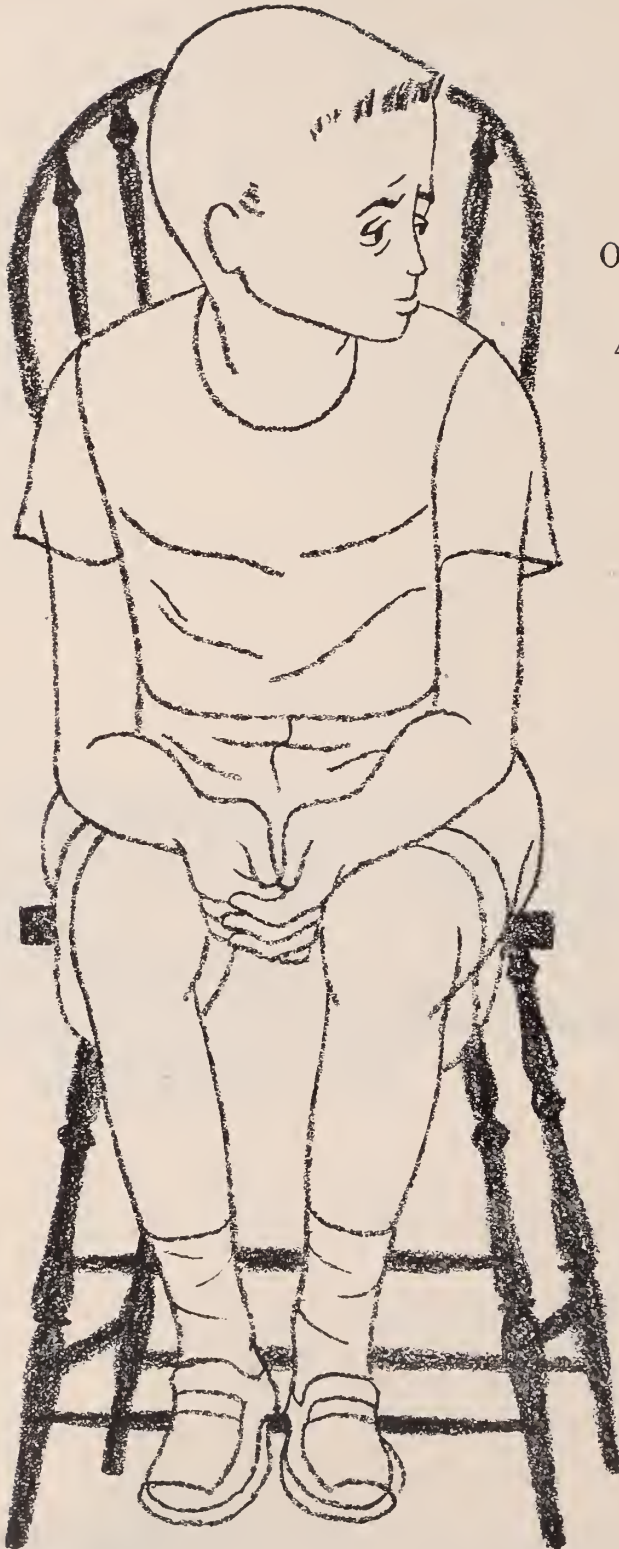


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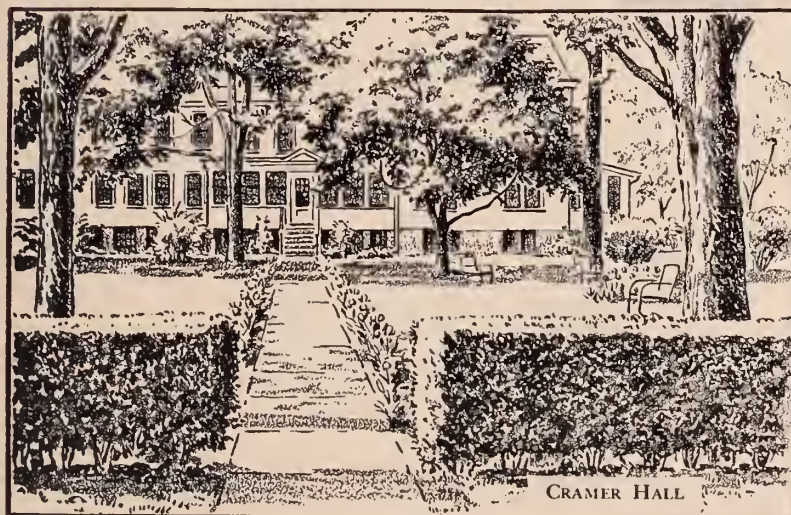
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1. Cook, M. H.; Free, A. H., and Giordano, A. S.: *Am. J. M. Technol.* 19:283, 1953.

2. Gray, C. H., and Millar, H. R.: *Brit. M. J.* 4824:1361 (June 20) 1953.

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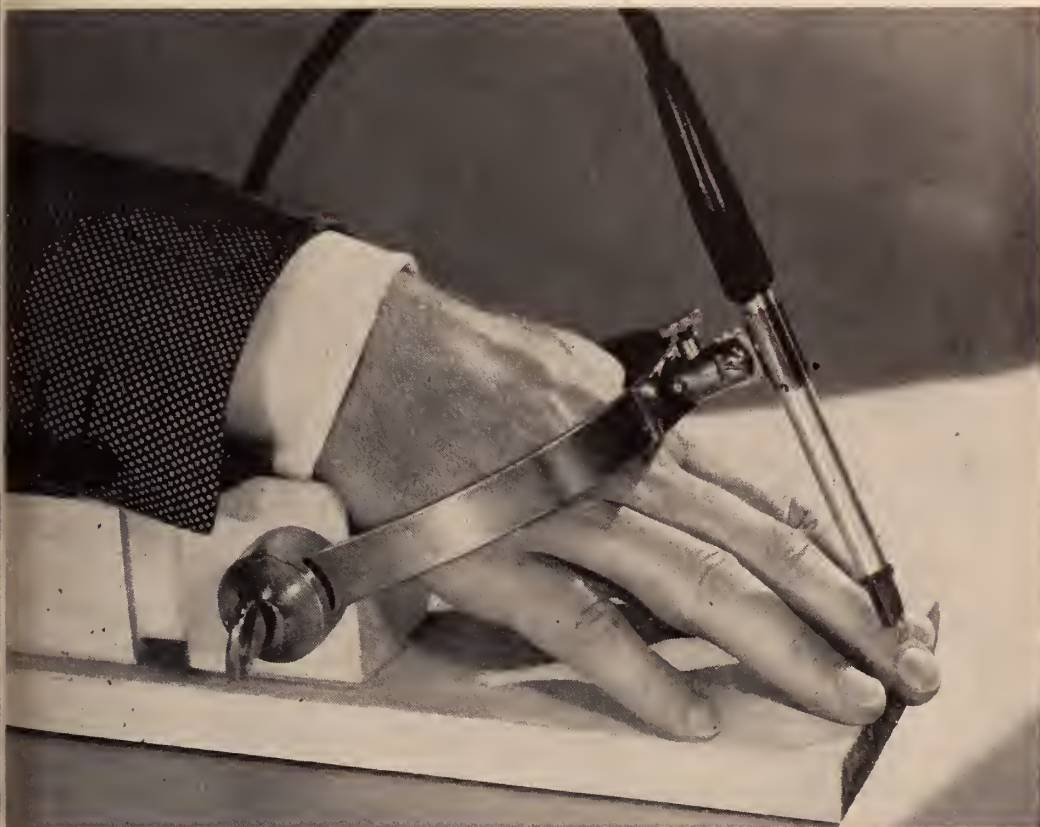
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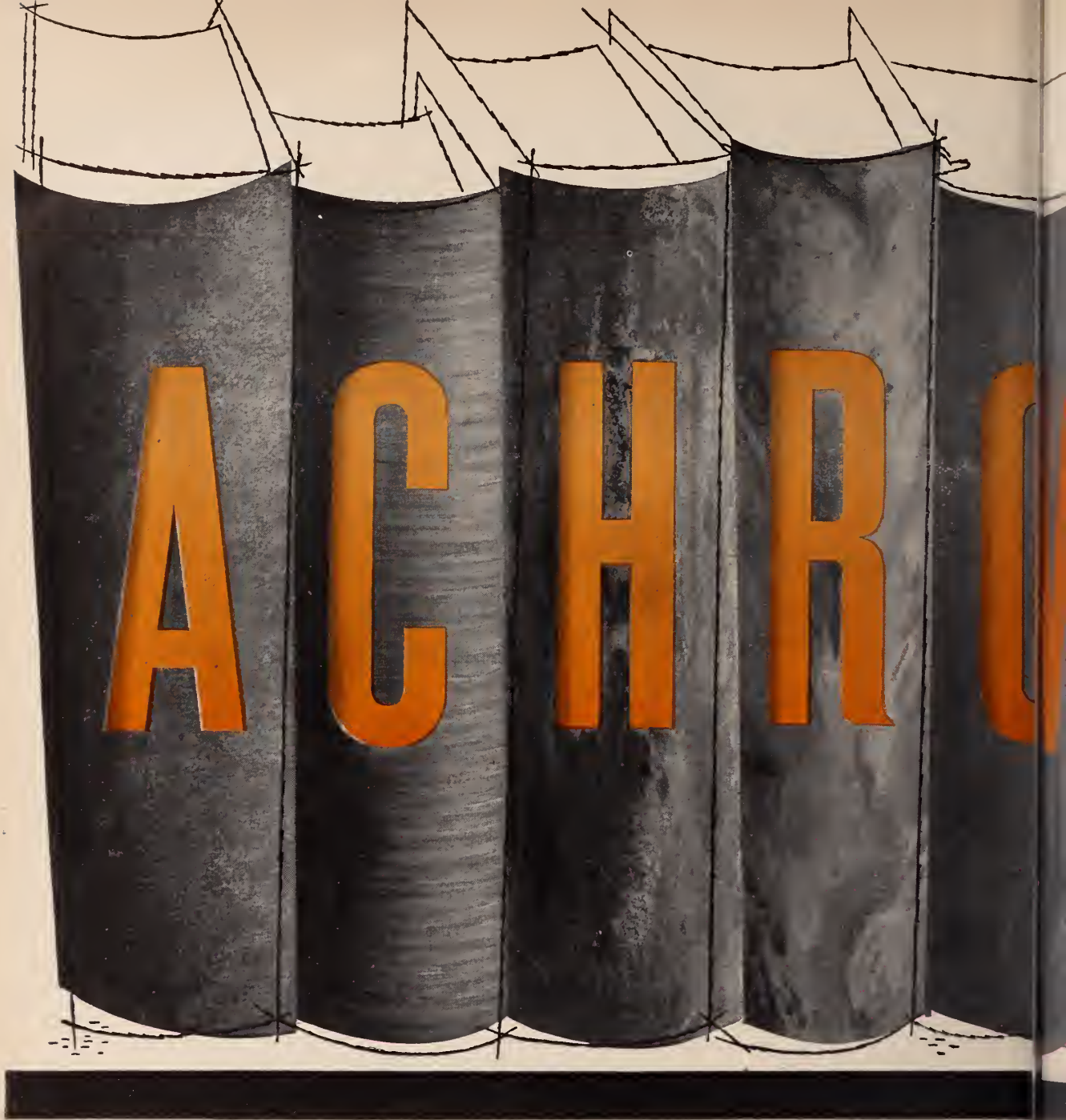
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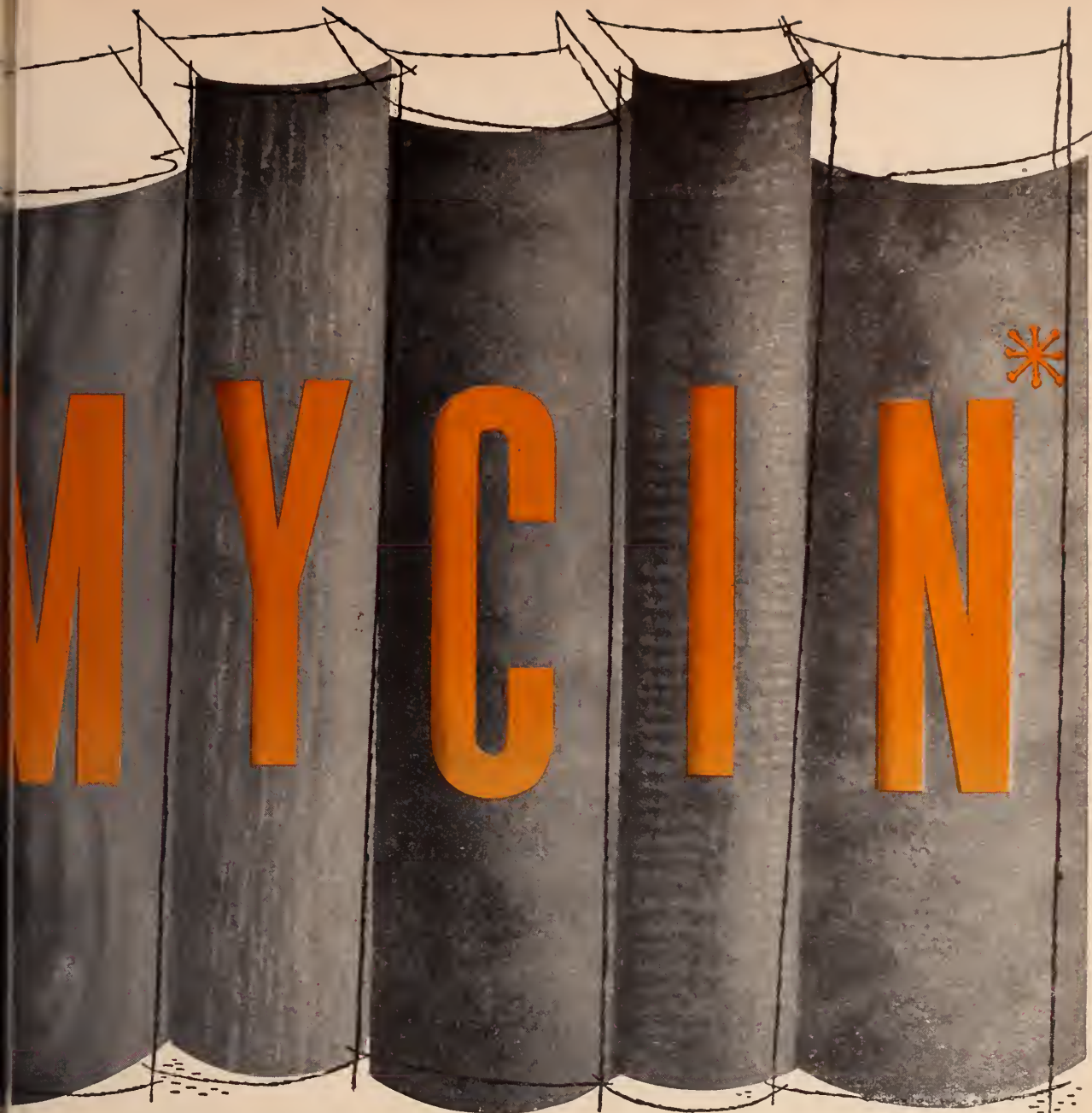
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1. Parsons, L., and Tenney, B., Jr.:
M. Clin. North America 34:1537,
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2. Greenblatt, R. B.: J. Clin. En-
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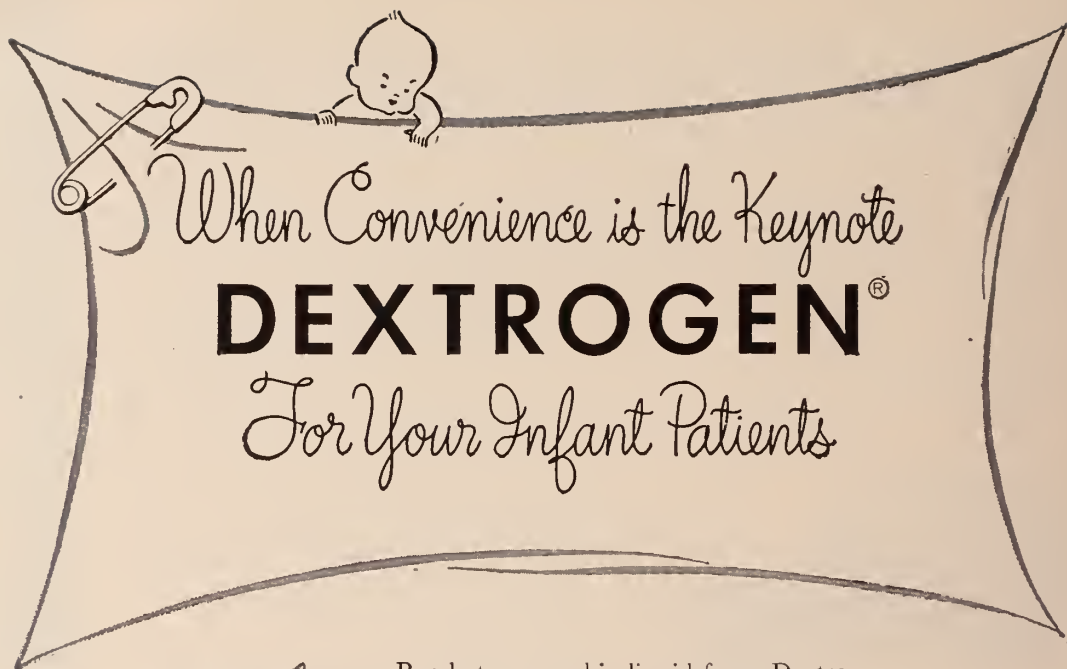
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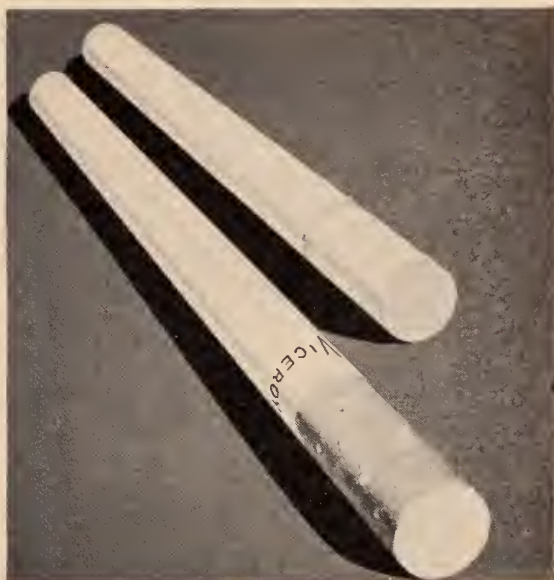
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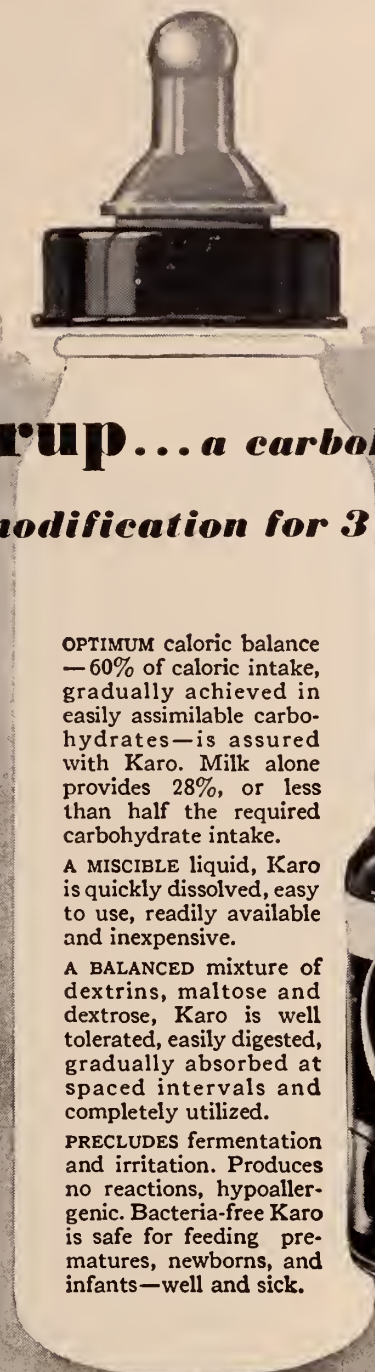
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Editorials • • •

The Decline of the House Call

Once the standard symbol of the medical practitioner, the little black bag seems headed for a museum. The house call is coming to account for less and less of the doctors' practice. The horse and buggy doctor would have included the maintenance of both the horse and buggy in his income tax deduction if they had income tax in those days. Making calls was a large part of his practice.

Now that transportation has become swifter, the doctor's need for it has become less. Some physicians practically never make house calls. Others do so with great reluctance and impose on the patient such discouraging obstacles as higher fees and tardy arrivals.

The reasons for this reluctance to make house calls are that the doctor is too busy, that equipment in the office is better or that the patient is not as sick as he thinks. This is quite in line with the trend of the times. Probably nothing that can be said or done now will reverse the trend. However before the house call becomes completely extinct we would like to utter this requiem.

There is nothing quite as challenging as a closed door. The doctor who has never waited for the door to open has lost out on one of life's interesting experiences. With today's modern diagnostic equipment it is much easier than it used to be to make a diagnosis. But in the home, the doctor must make a diagnosis with only the simple equipment he can carry in the bag plus his eyes, his ears, his fingers, his medical training and, one hopes, his God-given common sense. If he can do that, he is really playing in medicine's major league!

A patient sends for a doctor only when he considers himself in trouble. The doctor who responds is viewed as a friend in deed. Many harsh things have been said about medical practitioners during the last two decades. But no one ever says them about the doctor who is willing to reply to a cry for help by making a call to the home. Such a call may be time taking, economically profitless and subject to certain technical and scientific deficiencies. It is a cheerful symbol of service to people in trouble—a service which is the glory and the touchstone of our creed.

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Coxsackie Viruses*

Dalldorf and Sickles first isolated the Coxsackie viruses in the New York town bearing this name. They isolated a filterable agent from the stools of two patients with poliomyelitis. This agent was found to be pathogenic for suckling mice and further investigation showed that it caused skeletal muscle paralysis and necrosis in the mice within two to ten days. These investigators also found that the patient's sera as well as pooled human serum or gamma globulin contained neutralizing antibodies against this virus.

Further research showed that many viruses could be classed as Coxsackie viruses and they were divided into two groups, A and B, on the basis of the lesion produced in suckling mice. Group A viruses produce extensive lesions of skeletal muscle only, consisting of hyaline degeneration followed by necrosis and calcification. The group B viruses cause skeletal muscle necrosis plus central nervous system lesions and visceral inflammation. Within these two groups there are now at least fifteen immunologically distinct types.

The best test for identifying the presence of these viruses is the neutralizing antibody test. Unfortunately, at present it is complex and suitable only for research purposes. A number of surveys have shown that 40 to 80 per cent of all persons have neutralizing antibodies for any one of five types of the group A viruses. Similar studies show that 77 per cent of the general population are infected with Group B viruses.

Coxsackie viruses are completely resistant to ether, penicillin, streptomycin, chloromycetin and Aureomycin.[®] They are inactivated by heating to 51 to 60 degrees C. for thirty minutes. These viruses have a world wide distribution and there is no sex or race difference in incidence. They have been isolated from every age group, especially children and are more commonly found in the late summer. Spread is by direct contact, with all susceptibles becom-

ing infected, but only 30 to 50 per cent show clinical symptoms.

At present only two diseases are known to be related to the Coxsackie viruses: herpangina and epidemic pleurodynia. They apparently have no etiologic role in causing or aggravating poliomyelitis.

Herpangina was first described by Zahorsky in 1920. Its onset is sudden with fever, sometimes accompanied by a convulsion. Malaise and poor appetite are common as is vomiting. Headache is a prominent symptom and may be accompanied by abdominal and other pain. A mild to severe sore throat is often present. The fever usually subsides within 48 hours and the patient becomes free of symptoms a few days later. No laboratory and x-ray abnormalities have been described. The physical examination is normal.

The group A Coxsackie viruses have now been satisfactorily proved to be the cause of herpangina.

Pleurodynia is apparently caused by the group B Coxsackie virus. It was first described in Norway by Daae and Homann in 1872. The greatest number of cases is reported from the lowlands of Europe. Because one of the earlier epidemics occurred on the island of Bornholm the disease is frequently known as Bornholm disease. Other terms are epidemic myalgia and devil's gripe.

Pleurodynia is characterized by a sudden onset with fever, chest and abdominal pain, headache and increased fatigability. The chest and abdominal pain are usually most striking and are related to respiration. The symptoms may last for from one to twenty days and recurrences occur causing a prolonged convalescence. The disease, however, is benign and self-limited and no deaths have been reported.

The present status of the Coxsackie viruses can be summarized by saying that they are extremely widespread and that practically no one escapes infection with them. However, only 30 to 70 per cent of persons so infected show clinical symptoms.

R. D. G.

*Thinnes, J. L., Jr.: Coxsackie Viruses in Clinical Practice. Ohio State M. J., January 1954.

ALFRED R. HENDERSON, M.D.*

HOUSHANG HAKIM, M.D.**

Asbury Park

The Surgical Treatment of Coronary Heart Disease

Unilateral dorsal sympathectomy, pericardiopexy and internal mammary artery implantation are combined as a single operation in the treatment of coronary artery disease. Preliminary results in sixteen patients are described.

THE management of coronary heart disease has become one of the most common problems in general and cardiologic practice. The initial high mortality attending myocardial infarction and the significant percentage of cardiac cripples among the survivors has been responsible for a tremendous volume of research directed toward a better understanding of the coronary circulation in health and disease.

Disease of the coronaries is responsible for at least 200,000 deaths a year in this country alone.¹ An inkling of its importance can be seen in Bland and White's over-all figures for a ten year follow-up of their patients. Nineteen per cent died within the first four weeks and only one-third of the survivors recovered sufficiently to assume normal activity without symptoms after coronary occlusion. Only 31 per cent lived for more than ten years.² Massey³ states that 26 to 37 per cent of all individuals with heart disease have coronary involvement clinically and about one-third of these have angina pectoris. No practicing physician or anginal patient will dispute the seriousness and unpredictability of coronary heart disease. In

1896 Osler said: "One of the most distinguishing features of true angina is a consciousness . . . that the very citadel of life has been approached."⁴

SINCE the report of Herrick⁵ in 1912, emphasis has been placed on the role of coronary vascular occlusive processes as the prime mechanism in the production of myocardial ischemia and angina. In most cases there exists enough coronary sclerosis to account for angina or death because the coronary circulation is not adequate to meet the myocardial oxygen demands of the moment. In others, there is insufficient pathologic evidence to account for either angina or death from deficient coronary circulation.

The idea of coronary spasm, now not generally acceptable, was originally conceived to account for this discrepancy. On the other hand, supposedly significant pathologic changes have been found in the coronaries of patients who never had clinical evidence of myocardial ischemia and who died of other causes.⁷⁻¹⁰

Segers, Keating and Ward¹¹ and others have demonstrated that about 70 per cent diminution in coronary flow must occur before elec-

*Thoracic Surgeon: Monmouth Memorial, Fitkin Memorial and Riverview Hospitals.

** Resident in Surgery: Monmouth Memorial Hospital, Long Branch, N. J.

trocardiographic changes consistent with myocardial ischemia are seen. There is increasing evidence that diminished coronary flow does not account for the angina experienced by some patients who are often capable of considerable physical activity without symptoms. On the other hand, if the factor of conscious or unconscious emotional stress be added, all grades of angina can occur. It is not uncommon for a patient who experiences angina on the basis of emotional stress initially to develop exertional angina after learning of his heart disease since even physical effort will become a source of anxiety.¹²

THE problem, then, seems not to be entirely one of coronary vascular disease. In considering a surgical approach we must not think only of revascularizing the myocardium.

Surgery for coronary heart disease and angina is not new. As long ago as 1899, Francois-Franck¹³ suggested sympathectomy for relieving anginal pain. It was not until 1916, however, that the suggestion was carried out by Jonnesco,¹⁴ who performed a left cervical sympathectomy with dramatic relief to the patient. In the twenties numerous workers performed cervical sympathectomies, relieving about 30 per cent of their angina patients.¹⁵⁻²⁰ At this point, important anatomic contributions to our knowledge of cardiac innervation, (particularly the work of White, Garrey and Atkins²¹ in 1933) demonstrated the importance of the upper thoracic sympathetics in the mechanism of anginal pain. A brief wave of enthusiasm for paravertebral injection of these ganglia then followed with varied results.²² White²³ reported 75 per cent good and 21.3 per cent fair results with this treatment.

The role of the sympathetic nerve supply to the heart has taken on another meaning in recent years. Evans,²⁴ Gollwitzer-Meier,²⁵ Eckstein,²⁶ Raab,²⁷ and others have studied the significance of sympathetic stimulation and neurosecretory discharge of sympathetico-mimetic catecholines, particularly nor-epinephrine, in producing severe degrees of myocardial hypoxia in the presence of adequate coronary blood flow.

IT HAS been shown repeatedly that myocardial oxygen consumption occurring during such stimulation is far greater than that used simultaneously for cardiac work. The hypoxia-producing oxygen wastage by the myocardium under sympathetic stimulation occurs without an increase in cardiac work and is a specific chemical phenomena independent of cardiac dynamics. This neurosecretory function seems to be more important than coronary vascular sclerosis in a significant percentage of angina patients.

In recent years, surgeons have turned towards a more direct approach to overcoming myocardial ischemia by the production and development of collateral vascular channels. Patients who survive coronary occlusion and infarction are those who develop collateral flow between occluded coronary vessels and other coronaries (intracoronary collaterals) or neighboring mediastinal vascular networks (extracoronary collaterals). Three ways of surgically accomplishing effectual collateral flow have been developed under the term revascularization.

The first attempts to implant extracoronary collateral vasculature consisted of grafting foreign tissues upon the heart. Thus, omentum, pericardium, mediastinal areolar tissue, lung, chest wall musculature and diaphragm were sutured to the epicardial surface as a means of grafting upon the heart's surface potential vasculature which would form functional collaterals with existing surface coronaries. The results of these operations did not warrant their continued use.

A MORE direct attempt to effect extracoronary collateral flow has been developed by Vineberg.³² Vascularization of the left ventricle was accomplished experimentally and in humans by the implantation of an internal mammary artery into the myocardium. That significant arborization between the internal mammary and coronary arteries could be accomplished was confirmed by others.³³⁻³⁴ This operation protected animals against the effects of coronary sclerosis produced by cellophane wrapping of

a major coronary artery and yielded significant clinical improvement in humans.

The second approach to overcoming myocardial ischemia by surgical revascularization consisted of instilling various irritating substances into the pericardial sac to create a sterile granulomatous reaction. This inflammatory process produces a non-constricting adhesive pericarditis, thus conducting small vascular twigs into the myocardium via adhesions from the pericardium.³⁵⁻³⁶ Thompson,³⁷ using sterile dry magnesium silicate (U.S.P. talc), has recently summarized fourteen years' experience with the pericardiopexy operation. Fifty-seven patients are reported as having been operated upon from one to fourteen years previously. There was a total operative and immediate postoperative mortality of 12 per cent. Sixty-six per cent were still living at the time of this report. Ninety per cent of the living patients were improved more than 50 per cent. The conclusions are encouraging for a group of patients who were medical failures.

A THIRD method of revascularizing ischemic heart muscle, by arterialization of the coronary sinus and perfusing arterial blood through the coronary venous system, was first suggested by Roberts.³⁸ Preliminary extensive experimental work and human cases so treated were first reported by Beck and his co-workers.³⁹⁻⁴⁰ That arterial blood, carried from the nearby aorta via a vascular graft to the coronary sinus, can perfuse the coronary venous system and thence the arterial bed, has been proved experimentally. Such a procedure has been shown to protect a high percentage of dogs against the disastrous effects of subsequent coronary artery ligation.

Injection studies, reported by Bailey and his group,⁴¹ verify the continuous vascular plexus between the venous and arterial capillary beds within the myocardium. It is concluded by these authors that atherosclerotic obliteration of the arterial vascular bed can be successfully treated surgically by retrograde perfusion of the alternate venous route via tributaries of the coronary sinus.

*M*OST of the experimental results of the coronary sinus operation ("Beck procedure") seem promising. However, not all of the investigators agree concerning the applicability of the experimental conclusions. Some question the availability of such a retrograde flow to heart muscle. Johns, Sanford and Blalock⁴² found that perfusion of the coronary venous circulation with arterial blood resulted in rapid filling of the epicardial system of veins and return of the shunted blood to the atrium with a minimum of oxygenated blood recoverable in the smaller veins which communicate with the arterial capillary bed.

Parsonnet,⁴³ using injection studies of the coronary venous system in human hearts, casts doubt on the efficacy of arterializing the coronary venous system as a means of improving the supply of arterial blood to the myocardium. His anatomic studies indicate that a substantial area of myocardium (portion of the base and posterior surface of the left ventricle and interventricular septum) could not be adequately perfused via the middle cardiac vein.

Of interest in this connection is the series of reports of Eckstein and his group.⁴⁴⁻⁴⁶ Definite protection against ventricular fibrillation was afforded dog hearts in which coronary artery ligation followed arterialization of the coronary sinus, demonstrating that at least some of the capillary bed was perfused via coronary venous channels. Severe electrocardiographic changes postoperatively, however, demonstrated the inadequacy of the perfusion to approximate the original function of the arterial bed. The systolic bulging and dark color of the area involved supported this view. Furthermore, the instillation of India ink into the coronary sinus failed to inject the central septal area and injection of ink into the septal artery revealed that venous drainage did not occur into the coronary sinus.

Hahn and Kim⁴⁷ made thorough histologic studies following arterialization of the coronary sinus and coronary ligation. They demonstrated a dilated venous bed in the region of infarction and noted areas of scarring between the veins which suggested inadequate oxygen exchange through venous walls which could not function as thin-walled capillaries.

IT SEEMED reasonable that the good to fair results reported by others treating coronary insufficiency by various single surgical procedures (denervation, pericardiopexy and internal mammary implantation) might be effectively increased by the employment of all three at one operation. During the past twelve months, sixteen patients with clinical evidence of intractable coronary insufficiency have been subjected to surgery. In each instance a left upper dorsal sympathectomy ($T_1 - T_5$), pericardiopexy (magnesium sulphate) and internal mammary artery implantation was accomplished as one combined procedure.

Table 1. summarizes the important clinical data in each case. The efficacy of this form of surgery can only be surmised, since sufficient time has not elapsed to draw definite conclusions from the postoperative data to date. Some idea of the possibilities of this method in dealing with intractable coronary disease can be obtained, however, by virtue of the fact that these patients have all been improved or are improving to a degree not achieved by previous medical treatment.

CAREFUL preoperative and postoperative management has resulted in no operative deaths in the series and only one postoperative death from coronary occlusion eight days following surgery. The operative procedure itself appears relatively safe.

We do not know when a patient has developed sufficient collateral coronary circulation following surgery to enable him to resume normal or near normal activity. The experimental work of others has shown demonstrable vascularization in pericardiopexy operations within four to six weeks. A carefully implanted mammary artery will conduct blood within four weeks. However, since most experimental work has been done in animals, which differ from humans in that there is no true coronary insufficiency, we have extended the postoperative period of voluntary disability to three months. Our one death occurred in a patient who was allowed the freedom of the ward by the eighth postoperative day.

Numerous investigations have demonstrated the uselessness of drugs, in general, to influence the development of coronary collaterals. Since one drug, sodium nitrite, seemed to influence the rate of development of such intercoronary collaterals,^{48,49} a number of these patients (with normal or elevated blood pressures) have been given the drug for two weeks postoperatively for what it may be worth.

Unilateral excision of the left upper dorsal autonomic chain does not appear to affect significantly the sensory phenomena of angina. Most patients have continued to experience angina which, interestingly, decreased with time. To denervate completely the heart in these cases would not seem wise since angina serves as a watch-dog, warning of the need for cessation of activity and for rest and medication. Afferent pain pathways remain in the contralateral sympathetic, vagi and phrenic nerves.⁵⁰

SELECTION OF CASES FOR SURGERY

ALTHOUGH it may be wrong to deny operation to those who do not today appear to be hopeless enough to warrant surgery, we have restricted our cases to individuals who have proved themselves medical failures. These are relatively young patients who persist with angina and disability, with or without proved infarction, and who fail to improve during a year or more on a properly disciplined medical regimen. However, our oldest patient, 62 years of age, appears to be one of our best results at present. When surgery proves to be reasonably safe and proof of lasting success is obtained, we believe, since recurrence is the rule in coronary disease,⁵¹ patients now considered too well for such heroic therapy may become our ideal candidates.

SUMMARY

1. A brief discussion of the clinical and physiopathologic problems involved in coronary heart disease is presented in reference to the practicability of surgical therapy.
2. An outline is presented of the various

TABLE 1. CLINICAL SURVEY OF OPERATED CASES

Case	Age	Sex	Length of Coronary History	Work or Exercise Capacity	Last Known Occlusion		Preoperative Progress	Operative Course	Immediate Postoperative Course
					(Months)	Preoperatively)			
J.C.	42	M	18 months	Limited to short walks	18	No improvement	Uneventful	One severe anginal episode on 7th day	
L.B.	48	F	4 years	Periodic angina at rest				Works 8 hours daily (10 months postoperative)	
				Limited to light house work	12	No improvement	Uneventful	Uneventful until 8th postoperative day; died of massive occlusion	
R.O.	37	M	14 months	Light office work	14	Only slight improvement	Uneventful	Sustained infarction 4 weeks postoperatively. Recovered, improved 6 months postoperatively	
C.G.	39	M	2 years	Limited to short walks	6	No improvement	Uneventful	Progressive improvement. Works 4-6 hours a day	
N.B.	42	M	2 years	Capable of light work	7	No improvement	Uneventful	Recurrent angina for 6 weeks, then asymptomatic	
E.L.	58	F	4 years	Bedfast	?	Progressive deterioration	Uneventful	Slight periodic angina. Progressive improvement	
J.S.	62	M	6 years	Bedfast	4	No improvement	Uneventful	Progressive improvement. (4 weeks postoperatively)	
T.L.	41	M	16 months	Capable of light work	16	No improvement	Uneventful	Progressive decrease in angina. Works 6-8 hours daily	
J.C.	44	M	3 years	Limited to short walks		No improvement	Uneventful	Progressive improvement. (6 weeks postoperatively)	
T.S.	49	M	9 years	Limited to short walks		Progressive deterioration	Uneventful	No angina 4 months postoperatively	
M.B.	49	F	1 year	Light house work	12	No improvement	Uneventful	Only slight improvement to date. (2 months postoperatively)	
L.V.	55	M	2½ years	Limited to light work	30	Progressive deterioration	Uneventful	Progressive improvement. (4 months postoperatively)	
M.M.	39	M	18 months	Limited to light work	18	No improvement	Uneventful	Only 2 weeks postoperatively	
H.B.	50	M	14 months	Bedfast	14	No improvement	Uneventful	Progressive improvement. (3 months postoperatively)	
M.H.	50	M	3 years	Limited to light work	?	Slight improvement	Uneventful	Progressive improvement, 5 months postoperatively. (light work)	
G.K.	44	M	20 months	Limited to light work	20	Slight improvement	Uneventful	Slight improvement. (3 weeks postoperatively)	

operative measures developed in the management of coronary heart disease.

3. The rationale of the operative approach selected by the authors is discussed.
4. Sixteen cases of coronary insufficiency are presented in whom a combination of

internal mammary artery implantation, left upper dorsal sympathectomy and pericardioplexy was performed at one operation. There were no operative deaths; one patient died on the eighth postoperative day from a coronary occlusion.

710 Grand Avenue

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FRANK L. ROSEN, M.D.

JACOB SCHMUKLER, M.D.

ALLEN WELKIND, M.D.

Newark

Medical Opinions on Smoking

A survey of 5300 New Jersey physicians explores in detail their reactions, motives, and symptoms which may come from smoking.

WHEN Columbus brought tobacco back to the old world, he started a burning controversy which has not yet stopped smoldering. From the time of its introduction, smoking has had a universal appeal. A mass of literature has accumulated, debating its uses, abuses, and effects on health.

As physicians practicing allergy, peripheral vascular disease and cardio-respiratory medicine, we were curious to know its effects on patients. Our experience has been that some

people are adversely affected by the use of tobacco. We hope to be able eventually to screen out, before the damage is done, those individuals who are susceptible to its harmful effects, temporary and permanent.

Because our own experience is, of necessity, limited, we thought it valuable to get the opinion of a large group of physicians. Therefore, we sent out the following letter and questionnaire to the physicians of Essex County.

What Do Doctors *Really* Think

About Smoking?

The Tobacco Study Group, consisting of three New Jersey physicians, is doing research on the effects of smoking on health. This is a purely scientific survey *directed to physicians only*. It is not sponsored by tobacco companies or anti-tobacco organizations.

Non-smokers as well as smokers: *Please fill out this questionnaire completely!*

All replies are anonymous and confidential. Your prompt response to the enclosed questionnaire will assist immeasurably in compiling this vital information.

Tobacco Study Group,
Frank L. Rosen, M.D.
Jacob Schmukler, M. D.
Allen Welkind, M.D.

TOBACCO SMOKING SURVEY

Age: ☐ 20-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-over

Marital Status ☐ S ☐ M ☐ D ☐ W

Do you smoke now? ☐ YES ☐ NO

If you do not smoke now, did you ever smoke? ☐ YES ☐ NO

Some people try smoking, find it unpleasant and never smoke again. Did you? ☐ YES ☐ NO

If you smoke now or did smoke—How many? Do you or did you inhale? ☐ YES ☐ NO

(a) Cigarettes, per day ☐ 1-10 ☐ 11-20 ☐ 21-30 ☐ Over

(b) Cigars, per day ☐ 1-3 ☐ 4-7 ☐ 8-11 ☐ Over

(c) Pipefuls, per day ☐ 1-3 ☐ 4-7 ☐ 8-11 ☐ Over

If you smoked and have stopped for over a year, how many years did you smoke? ☐ 1-5 ☐ 6-10 ☐ Over

If you now smoke or have smoked, at what age did you start?

☐ 10-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-over

Does or did smoking give you any of the following symptoms? ☐ YES ☐ NO

General

- ☐ Tire easily
- ☐ Irritability
- ☐ Insomnia
- ☐ Tremor

Head

- ☐ Headache
- ☐ Migraine
- ☐ Dizziness
- ☐ Vertigo
- ☐ Faintness

Eyes

- ☐ Redness
- ☐ Blurring
- ☐ Scotomata
- ☐ Burning
- ☐ Tearing

Ears

- ☐ Buzzing
- ☐ Deafness
- ☐ Clicking

Nose

- ☐ Stuffiness
- ☐ Discharge
- ☐ Post-nasal drip
- ☐ Itching
- ☐ Sneezing
- ☐ Nosebleeds
- ☐ Anosmia

Throat

- ☐ Hoarseness
- ☐ Soreness
- ☐ Itching
- ☐ Tickling
- ☐ Hawking
- ☐ Salivation
- ☐ Burning of Tongue

Cardio-Respiratory

- ☐ Cough
- ☐ Expectoration
- ☐ Wheezing
- ☐ Hemoptysis
- ☐ Chest Pain
 - ☐ Substernal
 - ☐ Precordial
 - ☐ Pleuritic
- ☐ Dyspnea
- ☐ Palpitation
- ☐ Extra Systoles
- ☐ Rapid Pulse

G. I.

- ☐ Heartburn
- ☐ Hyper-acidity
- ☐ Belching
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation

- ☐ Diarrhea
- ☐ Epigastric Pain
- ☐ Post-prandial Pain
- ☐ Cramps
- ☐ Loss of Appetite
- ☐ Increased Thirst

G. U.

- ☐ Frequency
- ☐ Burning
- ☐ Dysuria
- ☐ Urgency
- ☐ Colic

Skin

- ☐ Hives
- ☐ Eczema
- ☐ Pruritus

Peripheral Vascular

- ☐ Numbness and tingling
- ☐ Coldness of the extremities
- ☐ Color change:
 - ☐ rubor
 - ☐ pallor
- ☐ Pain on walking
- ☐ Night cramps
- ☐ Swelling
- ☐ Sweating

Did your symptoms disappear or improve when you stopped? ☐ YES ☐ NO

If you stopped, was it for reasons of health? ☐ YES ☐ NO

If you are now smoking, would you like to stop? ☐ YES ☐ NO

Have you ever tried to stop? ☐ YES ☐ NO Many times? ☐ YES ☐ NO

If you no longer smoke, do you still have the craving? ☐ NO ☐ MILDLY ☐ STRONGLY

Do you or did you enjoy smoking for any of the following reasons?

DID IT OR DOES IT

- ☐ Relieve tension?
- ☐ Keep you relaxed?
- ☐ Relieve pain?
- ☐ Relieve boredom?
- ☐ Help wake you?
- ☐ Give you a lift when depressed?
- ☐ Make you at ease in a group?
- ☐ Make you more alert?
- ☐ Steady your nerves?
- ☐ Help you concentrate?
- ☐ Improve your appetite?
- ☐ Reduce your appetite?
- ☐ Help you think more clearly?
- ☐ Stimulate defecation?

DID YOU OR DO YOU ENJOY

- ☐ The taste?
- ☐ The aroma?
- ☐ The stimulation of inhaling?
- ☐ The feel in your lips?
- ☐ Holding the cigarette, cigar or pipe?
- ☐ A smoke especially after a meal?

Other Reasons?

What is your impression about the effects of smoking on health?

Encouraged by the interest exhibited by the large proportion of returns, we then sent an emended questionnaire to the other members of The Medical Society of New Jersey.

There have been many studies of the smoking habits of various segments of the population but, so far as we know, no study directed exclusively to physicians. Of all groups that could have been investigated, physicians should be best qualified to describe their reactions to smoking.

THE roster of The Medical Society of New Jersey in 1953 listed 5300 physicians. Questionnaires were sent to the entire membership in the first quarter of 1953. There were 1699 replies (32%) of which thirty had to be discarded because they were incompletely answered.

The questionnaire is concerned primarily with the doctors' *own* smoking experiences and opinions. The results are tabulated and evaluated in the same sequence as they appear in the original questionnaire. Physicians were classified as smokers, former smokers, or non-smokers.

Question 1. Age (1427 answers)

			Never smoked	Former smokers	Smokers
	Total	Approx.	%	%	%
20-30 years	53		4	19	64
31-40 years	424	29	13	28	59
41-50 years	575	41	12	33	55
51-60 years	235	16	10	38	52
61 and over	140	10	13	45	42

Seventy per cent of the answers to this question came from physicians between the ages of 31 to 50 years. Note that there are fewer smokers in the older age groups. The percentage of doctors who gave up smoking increased markedly with advancing age. The percentage who never smoked in each category is much the same. This would suggest that, with increasing years, two situations arise which make the physician abandon the use of tobacco. First, the symptoms caused by many years of smoking may become more troublesome; second, various infirmities of age may be aggravated

by smoking. It may also be, in part, a reduction in the deeper psychologic need for the benefits derived from smoking.

Question 2. Marital status (1605 answers)

	Single	Married	Divorced	Widowers
Never smoked	11 (16%)	157 (11%)	4 (19%)	1 (3%)
Former smokers	16 (23%)	426 (29%)	3 (14%)	10 (36%)
Smokers	42 (61%)	894 (60%)	14 (67%)	17 (61%)

It seems that marital status does not influence the use of tobacco.

3. Do you smoke now?

1669 answers 1014 (60.8%) yes

It is significant to note that 39.2% of the doctors who answered were not smokers at the time of the survey. This figure also includes those who never smoked.

4. If you do not smoke now, did you ever smoke?

477 (28.5%) yes

This group whom we designate as "former smokers," is further described in question seven.

5. Some people try smoking, find it unpleasant and never smoke again—did you?

114—yes 64—never tried smoking

A total of 178 were classified as non-smokers, of this group 114 tried it and discontinued its use. Sixty-four doctors never smoked.

6. Do you or did you smoke cigarettes, cigars, or pipes?

(1669 answers)

1522 smokers and former smokers

66% or 1101 doctors smoke cigarettes chiefly, of whom 86% smoke cigarettes only.

20% or 330 smoke cigars chiefly, of whom 54% smoke cigars only.

14% or 253 smoke pipes chiefly, of whom 34% smoke pipes only.

Approximately 2% smoke all three.

The percentage who smoke cigarettes seems to compare to the results of surveys carried out among the general male population of similar age groups.

6a. Do you inhale?
(1522 answers)

66% of the smokers inhale. As compared to cigarette smokers, very few cigar and pipe smokers inhale.

7. If you smoked and have stopped for over a year how many years did you smoke?
(477 answers)

22% or 103 smoked from one to five years.
16% or 77 smoked from six to ten years.
50% or 236 smoked over ten years.
12% or 60 did not answer this question.

The largest group of former smokers were those who had smoked for ten years or more.

8. At what age did you start smoking?

(answered by 1522 smokers and former smokers)
8% started to smoke between the ages of ten and fifteen.

50% started to smoke between the ages of sixteen and twenty.

37% started to smoke between the ages of twenty-one and thirty.

4% started to smoke between the ages of thirty-one and forty.

1% started to smoke at forty-one and over.

Over one half started to smoke before twenty-one and more than one third between twenty-one and thirty. Very few began smoking after thirty years of age.

9. Does or did smoking give you any of the following symptoms?

(Response of 1522 smokers or former smokers; symptoms listed in order of frequency of occurrence)

Symptoms	Total	Symptoms	Total
Cough	472	Irritability	151
Burning of tongue	394	Wheezing	141
Postnasal drip	375	Nasal discharge	137
Hawking	359	Vertigo	133
Stiffness of nose	293	Precordial pains	117
Expectoration	275	Faintness	117
Heartburn	263	Tremor	109
Fatigue	231	Sneezing	107
Rapid pulse	223	Burning of eyes	105
Dizziness	220	Dyspnea	102
Headache	202	Redness of eyes	100
Tickling of throat	199	Nausea	99
Hoarseness	197	Tearing	94
Extrasystoles	193	Coldness of ex-	
Hyperacidity	191	tremities	89
Substernal pain	166	Insomnia	88
Loss of appetite	163	Numbness and	
Sore throat	157	tingling	84
Palpitation	153	Salivation	72

Symptoms	Total	Symptoms	Total
Belching	68	Ear buzzing	25
Thirst	64	Abdominal cramps	23
Diarrhea	46	Constipation	21
Epigastric pains	45	Frequency	20
Night cramps (legs)	45	Deafness	16
Blurring of vision	41	Clicking in ears	16
Pallor of limbs	37	Vomiting	15
Migraine	36	Rubor of limbs	15
Pleural pain	36	Pruritis	9
Scotoma	34	Postprandial pain	8
Claudication	34	Hives	5
Sweating	34	Burning on urination	4
Nasal itch	30		

RESPIRATORY SYMPTOMS

AS CAN be seen from the symptoms presented in the above table, the respiratory tract, from the mouth and nose down to the alveoli, is most frequently involved. It is well known that cough and many other symptoms of the upper respiratory tract can be due to smoking in certain individuals. In order of frequency, respiratory symptoms are cough, postnasal drip, hawking, stuffiness of the nose and expectoration. Less frequent complaints are tickling of the throat, hoarseness, sore throat, wheezing, nasal discharge, sneezing and dyspnea.

Cough was the most common symptom attributed to smoking. This was present in 31 per cent and was accompanied by expectoration in 18 per cent. In fact, smoking is considered to be one of the most frequent causes of cough. Too often, patients with severe pulmonary disorders delay seeking medical advice because they attribute their coughs to smoking. Not as well known is the fact that postnasal drip, "the great American symptom," may also be the result of tobacco. This was found in 24 per cent of the replies in this survey. Hawking was specifically mentioned by 23 per cent. Of interest to the allergist and otolaryngologist is the high incidence of nasal complaints (19 per cent).

GASTRO-INTESTINAL SYMPTOMS

ANY portion or the entire gastro-intestinal tract may respond adversely to smoking in some individuals. The more common symptoms are burning of the tongue, heartburn, "hyperacidity," and loss of appetite. (It is not

easy to distinguish between heartburn and "hyperacidity," subjectively. The two conditions may be the same symptoms). Less frequent symptoms are nausea, salivation, belching, thirst, diarrhea, and epigastric pain. The incidence of complaints such as burning of the tongue (25%), heartburn (17%), "hyperacidity" (12%), etc., justifies the practice of gastroenterologists, who interdict smoking for the majority of their patients.

CARDIAC SYMPTOMS

THE organ next most affected is the heart.

The common reactions which manifest themselves are rapid pulse (15%), extrasystoles (13%), substernal (11%) and precordial pain (8%), and palpitation (10%). There is still considerable controversy among cardiologists as to the effect of smoking on the heart. The core of this problem is the advisability or inadvisability of smoking for the cardiac patient. Since such symptoms are seen in people with apparently normal hearts, one might reasonably infer that harmful effects would more readily accrue to individuals with heart disorders. There are some cardiologists who feel that the psychologic benefits derived from smoking outweigh the adverse effects on the heart. Since so many physicians in this survey attributed cardiac symptoms to smoking, one should inquire carefully into the previous smoking history of the patient. Should these symptoms occur in any cardiac patient with a functional or organic disorder, he should be advised to abstain completely from tobacco.

GENERAL SYMPTOMS

A SIGNIFICANT group (15%) attributed fatigue to smoking. Other symptoms are dizziness (14%), headaches (13%), irritability (10%), vertigo (9%), faintness (8%), tremor (7%), insomnia (5%), and migraine (2%). Analysis of the records indicated that those who smoke to excess more frequently complain of fatigue. However, the problem of the production of fatigue is so complex that

further investigation of this important symptom is warranted.

Dizziness, vertigo and faintness are common symptoms of the "beginner." These also occasionally occur in inveterate smokers, and may be quite troublesome. Headache, present in 13% of our replies, has not been given sufficient medical attention. The toxic end-products of smoke could produce headache. The use of tobacco may be a factor in the production of migraine, even though it is found only in 2 per cent in this survey. Irritability, like fatigue, is a difficult symptom to evaluate.

OPHTHALMIC SYMPTOMS

OPHTHALMIC symptoms were burning (7%), redness (6%), tearing (6%), blurring of vision (2%), and scotomata (2%). Burning, redness, and tearing are frequently due to direct local effect of smoke on the superficial tissues of the eye. They also may be the result of an allergic reaction to tobacco smoke. Blurring of vision and scotomata are well known central toxic effects.

PERIPHERAL VASCULAR SYMPTOMS

THE most clearcut evidence of the effects of smoking on the human body occurs in the peripheral vascular system. Although the incidence is relatively low in comparison with the total number of smokers, there is no longer any question about the direct action of tobacco on the blood vessels in thrombo-angiitis obliterans and other organic occlusive and functional peripheral vascular diseases. Vascular complaints in this survey were coldness of the extremities (6%), numbness and tingling (5%), night cramps (3%), pallor (2%), intermittent claudication (2%), and rubor (1%). It is also physiologically certain that vasoconstriction occurs in all smokers and is therefore of major importance in those patients who already have impaired arterial circulation. From the comments made in answer to the last question of the survey, it was clear that most doctors are cognizant of this effect.

OTOLOGIC SYMPTOMS

BUZZING (2%), deafness (1%), and clicking (1%) occurred in that order. These symptoms are probably a reflection of other upper respiratory reactions to smoking, perhaps in relation to Eustachian tube dysfunction.

GENITO-URINARY SYMPTOMS

FREQUENCY, burning and urgency of urination were rare symptoms.

DERMATOLOGIC SYMPTOMS

ALTHOUGH pruritis and hives were both noted in less than one per cent in this survey, it might be wise to keep in mind that smoking may be the cause in obscure cases.

10. Did your symptoms disappear or improve when you stopped?

There were 1004 answers, of which 922 (92%) answered "yes," and 82 (8%) answered "no". It is striking to note the high incidence of improvement. This is possible confirmatory evidence of the role played by smoking in the production of the symptoms enumerated above. If these symptoms are present, a trial period of abstinence is indicated as a therapeutic test.

11. If you stopped, was it for reasons of health?

912 physicians answered, of whom 630 (69%) stated that they stopped for health reasons. The remainder, 282 (31%), stopped for unstated reasons. It is again obvious that many physicians feel that smoking may have a deleterious effect.

12. If you are now smoking, would you like to stop?

Of 1014 smokers who replied, 436 (43%) answered yes, 508 (50%) answered no and 70 (7%) did not reply. This is an indication that a representative group answered the questionnaire and that the response was not weighted by those categorically opposed to smoking.

13. Have you ever tried to stop smoking?

Of the 1014 smokers, 542 (53%) replied yes, 414 (41%) no, and 58 (6%) did not an-

swer. That 53 per cent of the smokers preferred to continue smoking again confirms that the response to the questionnaire was a representative one. Answers to the second part of this question, "many times" were of insufficient number to enable us to draw conclusions.

14. If you no longer smoke, do you still have the craving?

Of the 477 former smokers, 362 (76%) no longer have the craving; 89 (19%) still have a mild desire, and 6 (1%) have a strong urge to smoke again. Twenty (4%) did not answer. Many doctors are afraid to advise their patients to stop smoking when indicated because they fear that persistent emotional strain will follow due to prolonged craving. From our figures it can be seen that the vast majority do not suffer from a persistence of this strong desire.

15. Do you or did you enjoy smoking for any of the following reasons?
(1491 answers)

The following are the pleasurable effects of smoking in order of frequency:

Relieves tension	691 (46%)
At ease in a group	439 (29%)
Relieves boredom	395 (26%)
Keeps you relaxed	302 (20%)
Reduces appetite	267 (18%)
Stimulates defecation	192 (13%)
Lifts when depressed	167 (11%)
Helps concentrate	125 (8%)
Steadies nerves	124 (8%)
Helps wake you	82 (5.5%)
Helps think clearly	51 (3%)
More alert	41 (3%)
Improves appetite	29 (2%)
Relieves pain	4 (0.25%)

FROM the above list, one can see that the questions fall into three categories. These are 1) sedative, 2) stimulative, and 3) gastrointestinal. The sedative actions of smoking are relief of tension, achievement of relaxation, "steadying the nerves," and relief of pain. Boredom, an emotional state which consists of a lack of affect, is included in this group because it gives rise to tension if it persists for some time. We are also including in this category, "makes you feel at ease in a group," since being ill at ease contributes to the pro-

duction of tension. The response to this questionnaire indicates that most smokers feel that tobacco has a sedative effect. This is a generally accepted idea.

Less frequently encountered and not as thoroughly appreciated, are the stimulative effects of smoking. In this group are included, "gives a lift when depressed," increase in concentrating capacity, alertness and help in waking and thinking.

The third group consists of gastro-intestinal reactions. There were two effects on appetite. It was diminished for most and increased for a few, in a ratio of nine to one. We had often heard of the stimulating effects of smoking on gastro-intestinal peristalsis. The question, "does it stimulate defecation?" was asked to determine the incidence. It was noted that of the answers obtained, there was a significant number who replied in the affirmative, thus confirming the original surmise.

The sensory pleasures of smoking were next considered. The list follows:

16. Do you or did you enjoy smoking?
(1491 answers)

Smoking after meals	839 (56%)
Aroma	516 (34%)
Taste	459 (31%)
Stimulation of inhaling	375 (25%)
Holding cigarette, cigar or pipe	260 (17%)
Feel in lips	143 (10%)

The chief pleasure was smoking after meals. When smoking is interdicted for sound medical reasons, how often have we heard the plaintive cry, "Can't I have a cigarette after every meal?"

THERE are many people who enjoy the aroma and taste of tobacco and its smoke. Stimulation from inhaling is experienced and appreciated mainly by cigarette smokers. In contrast, cigar and pipe smokers, who rarely inhale, seem to derive pleasure from handling the cigars and pipes. The cigar smoker who chews an unlit cigar and the pipe smoker who bites on the stem are both familiar figures. These people obviously enjoy the "feel in the lips," as do many cigarette smokers. There

were few answers to the question, "other reasons" (for the enjoyment of smoking), and these were only elaborations of answers to the previous questions.

The last question, "What is your impression of the effects of smoking on health?" was added to allow the physicians to express not only their personal reactions but their professional experiences as well. Many physicians answered this question, often in great detail. In fact, so informative was the response that the material will be presented in a subsequent paper.

SUMMARY

A QUESTIONNAIRE was sent to 5300 New Jersey physicians to ascertain their personal experiences and opinions about smoking. There were 1669 valid responses. Seventy per cent of those who answered were between the ages of thirty-one and fifty years. There is no apparent relationship between marital status and the use of tobacco. The responders were classified in three groups: smokers (60.8%), former smokers (28.5%) and non-smokers (10.7%). Analysis of the types of tobacco used revealed that 66 per cent smoked cigarettes chiefly, 20 per cent cigars and 14 per cent pipes. Two per cent smoked all three. Sixty-six per cent of the smokers inhaled and with few exceptions these were the cigarette smokers.

Most doctors began smoking before the age of twenty-one. Fifty per cent of the former smokers had used tobacco for over ten years before giving it up.

An analysis of the age groups indicated that as age increased there was a proportionate increase in the number of doctors who stopped smoking. It is possible that the symptoms, produced by many years of smoking, became more troublesome or that the disabilities of age were aggravated by smoking. It may also be partly due to a reduction in the deep psychologic needs for the benefits of smoking.

The effects of smoking occurred chiefly in the respiratory tract. In order of frequency symptoms were cough, postnasal drip, hawking, stuffiness of the nose, and expectoration.

The gastro-intestinal tract was the next most commonly affected. Symptoms here were burning of the tongue, heartburn, and hyperacidity. Cardiac symptoms were the third most frequent complaints. These were rapid pulse, extrasystoles, substernal and precordial pain, and palpitation.

A SIGNIFICANT group complained of fatigue as a result of smoking. There were other general symptoms of lower incidence. Migraine, although infrequent, may be mentioned as a possible allergic reaction to tobacco. Ophthalmic, dermatologic, and genito-urinary complaints were few. The most clearcut effect of smoking was seen in the peripheral vascular system, although its incidence was relatively low.

IN GENERAL, most physicians feel that smoking produces symptoms. This was confirmed in their personal experience by the disappearance or reduction of the severity of symptoms in 92 per cent of those who stopped for any

appreciable time. Considerable numbers of doctors had quit because of "health reasons." If there is doubt as to the cause of any of the symptoms enumerated above, a trial period without smoking is indicated. It is striking to note that 43 per cent of the smokers expressed a desire to stop, while 50 per cent did not. Fifty three per cent, who were smoking at the time of the survey, had tried at one time or another to give up smoking in the past. The vast majority who gave up smoking did not have a persistent strong craving.

Consideration of the pleasurable effects of smoking leads to the conclusion that tobacco "is all things to all men." However, in this study the greatest effect was a sedative one. For most, it relieved tension. To a lesser degree, it was a stimulant in that it elevated the mood. For others it was a definite appetite depressant and gastrocolic activator.

The sensory pleasures of smoking play a major role in the continuation of the habit. The greatest enjoyment seems to come in the "smoke" after meals. The aroma, taste, inhalation, holding the cigarette, etc., and feel in the lips contribute other sensory effects.

32 Johnson Avenue

Jersey Beaches Found Safe

The State Department of Health finds that bathing beaches along the coast of New Jersey from Sea Bright to Cape May are safe for bathers. Beaches in the Raritan Bay area were said to be satisfactory except for those at Perth Amboy and South Amboy.

Determinations are based upon inspection of sewage treatment plants, bacteriologic analyses of the water, and previous years' experience.

In Monmouth and Ocean Counties, the sur-

vey was carried out by local health officials and water and sewage plant operators as a joint project of the Central State Health District of the State Department of Health and the Joint Committee on Bathing Beach Sanitation.

From Brigantine to Cape May, the tests were made by personnel of the Southern State Health District under the direction of Leigh Morrill, District Chief Public Health Engineer.

EMIL FRANKEL, Ph.D.*

Trenton

Mental Hospital Patients in New Jersey

The current status of more than 20,000 patients in the state's mental hospitals is analyzed statistically, and evaluated.

THE adoption of a revised Standard Nomenclature of Mental Disorders¹ by the American Psychiatric Association in 1951 made it necessary to apply new terms to more than twenty-thousand patients in the state and county mental hospitals of New Jersey, and to 6840 patients who entered these hospitals in the current fiscal year.

The Bureau of Social Research of the Department of Institutions and Agencies cooperated with medical staffs of these hospitals so that the resulting compilation may be "uniform, comparable and meaningful." It is hoped that the statistics may furnish reliable epidemiologic data about the frequency of mental disorders in various segments of the population. They also may help us learn what treatments are effective and under what conditions.²

CLASSIFICATION OF MENTAL DISORDERS

THE revised diagnostic scheme of mental disorders "attempts to provide a classification system consistent with the concepts of modern psychiatry and neurology. It recognizes the present-day descriptive nature of all psychiatric diagnoses, and attempts to make possible

the gathering of data for future clarification of ideas concerning etiology, pathology, prognosis, and treatment in mental disorders."¹ The term "disorder" is employed generically to designate a group of related psychiatric syndromes. Whenever possible, each group is further divided into more specific psychiatric conditions termed "reactions."

All mental disorders are divided into two major groups: 1) those in which there is disturbance of mental function resulting from, or precipitated by, a primary impairment of the function of the brain, generally due to diffuse impairment of brain tissue; and 2) those which represent a more general difficulty in the adaptation of the individual, and in which any associated brain function disturbance is secondary to the psychiatric disorder.

A brief description of the classification of mental disorders employed in the uniform statistical tabulations follows:

Acute brain syndromes from which the patient recovers. They are the result of temporary, reversible, diffuse impairment of brain tissue function such as is present in acute alcoholic intoxication or "acute delirium." The basic disturbance of the sensorium may release

*Chief, Bureau of Social Research, New Jersey State Department of Institutions and Agencies.

other disturbances such as hallucinations, transient delusions, and behavior disturbances of varying degree.

Chronic organic brain syndromes result from relatively permanent, more or less irreversible, diffuse impairment of cerebral tissue function. While the underlying pathologic process may partially subside, or respond to specific treatment, as in syphilis, there always remains a certain irreducible minimum of brain tissue destruction which cannot be reversed, even though the loss of function may be almost imperceptible clinically.

Psychotic disorders are characterized by a varying degree of personality disintegration, and failure to test and evaluate correctly external reality in various spheres. In addition, individuals with such disorders fail in their ability to relate themselves effectively to other people or to their own work. Included are schizophrenic, manic depressive, and involutional reactions.

Psychophysiologic autonomic and visceral disorders is a term used in preference to "psychosomatic disorders." The symptoms are due to a chronic and exaggerated state of the normal physiologic expression of emotion, with the feeling, or subjective part, repressed. Such long continued visceral states may eventually lead to structural changes.

Psychoneurotic reactions are characterized by "anxiety" which may be directly felt and expressed, or which may be unconsciously and automatically controlled by the utilization of various psychologic defense mechanisms (depression, conversion, displacement, etc.). In contrast to those with psychoses, patients with psychoneurotic disorders do not exhibit gross distortion or falsification of external reality (delusions, hallucinations, illusions) and they do not present gross disorganization of the personality.

Personality disorders are characterized by developmental defects or pathologic trends in the personality structure, with minimal subjective anxiety, and little or no sense of dis-

tress. In most instances, the disorder is manifested by a lifelong pattern of action or behavior, rather than by mental or emotional symptoms.

Transient situational personality disorders appear to be an acute symptom response to a situation without apparent underlying personality disturbance.

THE table below shows the general view of patients in state and county (mental) hospitals in fiscal year 1953:

TABLE 1. Incidence of Mental Disorders in Hospitalized Patients

Mental Disorder	Resident Population	First Admissions
Acute brain syndromes	0.6%	5.2%
Chronic brain syndromes	25.9%	45.2%
Associated with		
Meningoencephalitic and other central nervous system syphilis	4.1	1.4
Cerebral arteriosclerosis and senile brain disease	16.2	35.9
Psychotic disorders	64.1%	32.6%
Involutional psychotic reactions	3.4	5.2
Manic-depressive reactions	7.7	3.8
Schizophrenic reactions	47.8	19.7
All other disorders	9.4%	17.0%

The outstanding facts, revealed by these figures are that almost 65% of the more than 20,000 patients now in the state and county hospitals of New Jersey are suffering from psychotic disorders† (nearly fifty per cent with schizophrenic reactions); over thirty per cent of about 5,000 patients admitted for the first time likewise suffer from psychotic disorders (nearly twenty per cent with schizophrenic reactions). Among the total first admissions, chronic brain syndromes lead with more than 45% with cerebral arteriosclerosis and senile brain disease predominating.

†Since these are, essentially, mental hospitals, one would expect that close to 100 per cent would be suffering from "psychotic disorders." This is true, the confusion being due to the terminology. As Dr. Frankel uses it, the phrase "psychotic disorders" means "non-organic" psychoses. Senile and arteriosclerotic psychoses are not included in the "psychotic disorder" rubric, though of course they are "psychoses." If the term "functional" be used to describe schizophrenia, paranoia and manic-depressive psychoses, then what Dr. Frankel is saying, in effect, is that 65 per cent of the patients have "functional psychoses" and the rest have "organic psychoses."
—Editor

The term schizophrenic reactions is synonymous with the formerly used term dementia praecox. It represents a group of psychotic reactions characterized by fundamental disturbances, in reality relationships and concept formations with affective, behavioral and intellectual disturbances in varying degrees and mixtures. The disorders are marked by a strong tendency to retreat from reality, by emotional disharmony, unpredictable disturbances in stream of thought, regressive behavior, and in some, by a tendency to "deterioration."

CEREBRAL arteriosclerosis and senile brain disease may be mild, moderate or severe. These cases vary from mild organic brain syndrome with self-centering of interest, difficulty in assimilating new experiences, and "childish" emotionality, up to and including those so severely affected by senile brain disease as to require institutional care. Deterioration may be minimal or it may progress to a state of vegetative existence, with or without superimposed psychotic, neurotic, or behavioral reactions.

Of great social significance in the total mental health picture of the community is the fact that a sizeable proportion of mental patients enter the hospital in the prime of life as table 2 shows.

TABLE 2. Age Incidence of Mental Disorders

Age	Resident Population	First Admissions
Under 25 years	2.8%	8.4%
25 to 44 years	27.7	31.3
45 to 64 years	40.1	24.5
65 years and over	29.4	35.8

It will be seen that more than thirty per cent of the hospital population are less than forty-five years of age; and nearly forty per cent of first admissions to mental hospitals are under this age.

From the standpoint of devising an effective program for the control and prevention of mental disorders it becomes extremely important to know not only the extent to which the different mental disorders occur in society, but also the age groups predominantly affected.

Tables 3 and 4 present the age and sex occurrence for the more common mental disorders among first admissions to state and county mental hospitals.

It is fully recognized that the attack on mental disorder must be carried on on all fronts. The facts which we have been able to compile on the basis of the revised nomenclature makes it possible to pinpoint more precisely the numerical importance of the different mental disorders and recognize the relative severity which they present from the standpoint of hospital

TABLE 3. Mental Disorder and Age of Male Patients

Mental disorder	Number	Percentage distribution		
		Under 45 years	45-64 years	65 years and over
Total	2499	41.9%	26.1%	32.0%
Acute brain syndromes	204	59.8	34.3	5.9
Chronic brain syndromes	1099	9.9	23.0	67.1
Associated with				
Meningoencephalitic and other central nervous system syphilis	45	20.0	68.9	11.1
Cerebral arteriosclerosis and senile brain disease	801	—	13.4	86.6
Psychotic disorders	665	69.9	27.5	2.6
Involuntional psychotic reactions	79	1.3	91.1	7.6
Manic-depressive reactions	65	33.9	55.3	10.8
Schizophrenic reactions	433	89.3	10.2	0.5
All other disorders	531	66.5	27.3	6.2

TABLE 4. Mental Disorder and Age of Female Patients

Mental disorder	Number	Percentage distribution		
		Under 45 years	45-64 years	65 years and over
Total	2461	37.4%	22.9%	39.7%
Acute brain syndromes	54	51.9	42.5	5.6
Chronic brain syndromes	1140	4.2	14.6	81.2
Associated with Meningoencephalitic and other central nervous system syphilis	22	18.2	72.7	9.1
Cerebral arteriosclerosis and senile brain disease	981	—	10.1	89.9
Psychotic disorders	957	66.4	31.8	1.8
Involuntional psychotic reactions	180	12.8	84.4	2.8
Manic-depressive reactions	125	67.2	29.6	3.2
Schizophrenic reactions	545	86.8	13.0	0.2
All other disorders	310	67.7	22.6	9.7

treatment programs and preventive action in the community.

Considering the eight main groupings of mental disorders in the resident population and in first admissions, they rank in frequency in the order shown in table 5.

TABLE 5. Order of Frequency

Mental disorder	Rank in frequency	
	Resident Population	First Admission
Acute brain syndromes	6	4
Chronic brain syndromes	2	1
Psychotic disorders	1	2
Psychophysiologic autonomic and visceral disorders	7	8
Psychoneurotic reactions	5	5
Personality disorders	4	3
Transient situational personality disturbances	8	7
Mental deficiency	3	6

BACKGROUND STATISTICS ON MENTAL DISORDERS

THE grave social and medical problems of mental disorders faced by the communities of New Jersey today may be illuminated further by the following summary figures:

1. More than 20,000 civilian patients will be found at the present time in the nine state and county mental hospitals; 13,602 patients are in the three state mental hospitals and 6,532 in the six county mental hospitals.*

In addition there are 335 patients in the

criminal section of the Trenton State Hospital and 66 emotionally disturbed children in the Arthur Brisbane Child Treatment Center at Allaire.

2. Last year a total of 6,840 patients were admitted to the state and county mental institutions of which 4,960 patients were admitted for the first time and 1,880 patients had received care in mental hospitals before.

3. Discharges from state and county mental hospitals numbered 3,884 last year. Among 2,914 patients leaving the state hospitals to return to their respective communities, 75.6% were in the hospital less than six months (53.3% less than three months); and 86.9% returned to the community in less than one year.

4. In the last half century the number of mental patients in hospitals has increased nearly one-hundred per cent as against a general population increase of slightly over twenty-five per cent.

5. The increasing hospitalization for mental illness is especially marked among the senior members of our population. Twenty years ago the proportion of first admissions of pa-

*A total of 23,287 mental patients in institutions in New Jersey was recorded in the 1950 United States Census: 11,962 males (75.2 per cent in state, county and city hospitals, 23.9 per cent in federal hospitals, and 0.9 per cent in private hospitals), 11,325 females (97.8 per cent in state, county and city hospitals; and 2.2 per cent in private hospitals).

tients 65 years old and over was 17.6%; today that proportion has increased to 35.8%.

6. The 20,000 beds now occupied by patients in mental hospitals in New Jersey are more than the beds available in all other hospital facilities combined.

7. A few years ago existing overcrowding in state mental hospitals was recognized as one of the serious hindrances to effective therapeutic treatment of the patients. Through two bond issues, totaling fifty million dollars, which had received the general approval of the citizens of New Jersey, the bed capacity available to mental patients has been increased by several thousand beds.

Through this extensive building program under which housing for patient care was greatly improved and the building of a new state hospital at Ancora, the accepted standards for hospital bed needs in New Jersey have practically been met.

PREVENTION OF MENTAL ILLNESS

THE need to foster mental health through effective community action has long been recognized by the Department of Institutions and Agencies. It has endeavored to spread the knowledge of the principles of mental health and develop appreciation of early recognition of nervous and mental disorders. It has stressed

the importance of correcting minor mental disturbances which may contribute to more serious ailments in the future. It has encouraged the development of means by which all persons who show signs of mental disturbances, however slight, may be assured of early attention and appropriate treatment.

A real impetus to this program recently has come from the Governor of New Jersey, the Honorable Robert B. Meyner, who has declared:

"We are all deeply concerned over the high incidence of mental illness. Despite an extensive building program which has measurably increased our mental hospital bed capacity, we must face the fact that our building program will not stem the tide of our increasing State Hospital population.

"Our hospital programs should be based on the most modern concepts of treatment. We should shorten the stay of patients and hasten, whenever possible, their return to a useful life in their communities. We should give patients the maximum possible degree of medical and psychiatric attention.

"We should make greater strides toward building within our communities the resources for education with respect to mental and emotional ills, and for providing at the community level the early help which can prevent, in many cases, the onset of long term and often hopeless hospitalization."

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2. For details see the stimulating paper on "Uniform Mental Hospital Statistics" by Dr. R. H. Felix, Director, National Institute of Mental Health,

National Institutes of Health, Public Health Service, Dept. of Health, Education and Welfare, presented at the National Governors' Conference on Mental Health, Detroit, Michigan, February 9, 1954.

3. State Hospitals: Greystone Park, Marlboro and Trenton, County Hospitals: Essex, Hudson, Camden, Atlantic, Cumberland and Burlington.

The Pathogenesis of Pancreatitis

Current theories of the pathogenesis of acute and chronic pancreatitis are presented, with the conclusion that undoubtedly more than one cause underlies this disease.

ACUTE and chronic pancreatitis are more frequently diagnosed today because physicians are aware of them and laboratory facilities are available for their diagnosis. Serum amylase and lipase determinations and the employment of pancreatic secretion studies following the administration of secretin have contributed greatly to the increased frequency with which pancreatic disease is recognized. However, we still know little of the etiology of acute and chronic pancreatitis.

The most common causes that have been cited are regurgitation (of bile), obstruction (in the duct system), vascular occlusion and trauma. The finding of a common channel between the biliary and pancreatic ducts proximal to the ampulla of Vater that permits reflux of bile into the pancreatic system has served to make this an attractive etiologic theory. During cholangiography the pancreatic duct may be visualized in from seven to forty-seven per cent of patients, indicating the common ampullary orifice that exists.^{1,2} The association of gallbladder disease and pancreatitis is high.³ Nevertheless, numerous cases of biliary disease in which cholangiography has revealed a common channel have not been associated with disease of the pancreas. Also, in approximately 30 per cent of pancreatitis patients a normal gallbladder is present.^{3,4}

Experimental work shows that the presence of bile in the pancreatic duct without obstruction to the outflow of pancreatic juice will not produce a rise in serum amylase, i. e., indicating destruction of pancreatic acinar tissue.^{5,6}

Acute pancreatitis occurs only when the pancreatic ducts are obstructed while the gland is actively secreting. The development of fat necrosis will depend on the rate of secretion and the degree of intra-pancreatic pressure.

RICH and Duff,⁷ were among the first to emphasize the importance of obstruction of the pancreatic ducts as a cause of pancreatitis. They described pancreatitis caused by obstructing metaplastic plaques in the small pancreatic ductules.

Obstruction at the sphincter of Oddi due to spasm, inflammation or calculus also have been cited as common causes of pancreatitis. These observations provided the basis for surgical sphincterotomy in chronic pancreatitis.

Numerous studies have been done to determine the degree of pressure within the pancreatic system necessary to produce rupture of the acini and pancreatitis.⁵⁻⁸ Nevertheless, the evidence has left many questions unanswered. A number of authors have reported acute pancreatitis in patients in whom the pancreatic duct opened separately into the duodenum and consequently was not the site of obstruction. Others have failed to find any evidence of obstruction despite the common channel and still others believe that the accessory pancreatic duct of Santorini acts as a safety valve when the main duct is blocked.

Trauma as a cause of pancreatitis is recognized and well documented. Vascular occlusion due to arteriosclerosis of the pancreatic circ-

lation or venous stasis associated with hemorrhage may be another cause of pancreatitis.

While diabetes has often followed chronic pancreatitis, acute pancreatitis complicating pre-existing diabetes mellitus has not been recorded frequently. Two patients, both females without gallbladder disease and with long standing diabetes mellitus have been seen recently with typical attacks of pancreatitis. Presumably atherosclerotic changes in the pancreas were the cause.¹³ However, because of numerous instances in which satisfactory explanations could not be offered by presently accepted theories other etiologic factors have been sought for.

METABOLIC

PROTEIN DEFICIENCY. It is well known that in experimental animals morphologic changes in the pancreas develop along with fatty infiltration of the liver following long periods of a low-protein high-fat diet. The disease *kwashi-iorkor*, found in malnourished children and adults in certain parts of Africa who have long subsisted on low protein diets, is associated with a fibrotic pancreas.⁹ The clinical and pathologic findings in these patients resemble chronic pancreatitis as we see it in this country.

Ethionine: Farber and Popper¹⁰ employed ethionine, an antagonist of methionine, to induce fatty livers in animals. Rats injected intraperitoneally with ethionine revealed pathologic changes suggestive of acute pancreatitis. The hepatic lesions were accompanied by destruction of the pancreatic acini and later with fat necrosis in the gland. These changes were prevented when methionine was introduced simultaneously with ethionine.

These experiments were repeated by other investigators¹¹ in dogs and monkeys and similar results found. Inflammatory and degenerative changes in the pancreas were associated with elevation of serum enzymes and a decrease in external pancreatic secretion. The animals had histologic findings characteristic of acute and chronic pancreatitis: loss of cytoplasmic basophilia, swelling and vacuolization of the cytoplasm, loss of normal organization of the

acini, diffuse or focal necrosis of the acinar cells, fat necrosis, interstitial inflammatory reaction with or without hemorrhage, and late fibrosis. Ethionine appears to act specifically on the acinar cells; no lesions of the ducts, blood vessels or islets were seen. No apparent obstruction of the pancreatic ducts that could contribute to the elevation of blood enzyme levels was found.

The elevation of serum amylase and lipase results from a destruction of the cell barrier which normally prevents the entrance of pancreatic enzymes into the blood. These workers¹⁰ concluded that ethionine competitively inhibits methionine metabolism and that acute pancreatitis in their experimental animals was due to interference with normal utilization of methionine. The pancreas appears to be particularly susceptible to such metabolic handicaps because it is remarkably active in protein synthesis and turnover.

ALCOHOLISM. Patients with pancreatitis give a history of alcoholism in 20 to 30 per cent.¹² In a group of 19 patients under my observation, thirteen with acute and six with chronic pancreatitis, there was a history of alcoholism in 32 per cent. One of the patients with acute and three with chronic pancreatitis were bartenders with a long history of alcoholism.¹³ Ivy and Gibbs⁸ are of the opinion that acute pancreatitis in the alcoholic is a result of duodenitis with obstruction of pancreatic external secretion. However, previous studies have revealed that destruction of acinar cellular morphology is adequate and does not require obstruction to produce the pathology of pancreatitis.

A report¹⁴ based on an outbreak of acute methyl alcohol poisoning may provide further information on the metabolic (or toxic) factors responsible for the development of acute pancreatitis. In a series of 323 cases 14 random serum amylase studies were performed. Approximately 90 per cent revealed elevation above 300 units. High values were found after the first and up to the eighth day following the ingestion of methyl alcohol.

Striking hemorrhagic necrosis of the pan-

creas with destruction of the acini was found in those patients who died. In only one patient was edema of the duodenal mucosa reported. The elevation of serum amylase was not related to the administration of narcotics. Clinically, these patients were in extreme acidosis with a marked decrease in plasma bicarbonate, often to zero. The authors postulate that methyl alcohol, or its oxidation products, produces a severe depression of the oxidative enzyme systems. The upper abdominal pain in methanol poisoning previously attributed to intestinal spasm is more likely due to acute pancreatitis. The prompt relief afforded these patients by sodium bicarbonate infusions may indicate the role of severe acidosis in the symptom complex and suggests the use of this therapy in patients with acute pancreatitis.

HYPERLIPEMIA. The association of chronic relapsing pancreatitis and hyperlipemia has been reported occasionally in the literature. Heretofore it was presumed that the lipemia was a consequence of pancreatitis and a diagnosis of pancreatic lipemia was often given to the condition. Recently¹⁵ the subject has been more extensively reviewed. It is now presumed, on the basis of good clinical and laboratory evidence, that the pancreatitis is a result rather than the cause of the hyperlipemia. The term essential hyperlipemia is now preferred and should include those cases previously referred to as pancreatic lipemia.

In essential hyperlipemia the serum is grossly milky due to a marked increase in neutral fat from the normal of 3 to 4 m.Eq. to 40 or more m.Eq. per liter.* The cholesterol and phospholipid fractions are normal or slightly elevated. The disease is usually associated with xanthomatosis, another stigma of abnormal fat metabolism. The hyperlipemia and xanthomata antedate the onset of pancreatitis and evidence for a familial origin of this disease is especially striking.

In some patients with essential hyperlipemia it is possible to precipitate attacks of abdominal pain by raising the serum lipids. On the other

hand, dietary restriction of fat may produce a dramatic improvement in their symptoms. The production of pancreatitis in the hyperlipemic state has been thought to be caused by xanthomatous lesions in the pancreas, atherosclerosis, or vascular occlusion by clumped lipid particles (embolization). The lipemia itself may be related to a metabolic disorder involving fat transport across cellular membranes or in the deposition and removal of fat by the liver.

INFECTION

Numerous inconclusive experiments have been performed in an attempt to correlate infection of the gallbladder with pancreatitis both via the blood stream and lymphatics.¹⁶ Acute pancreatitis with elevated serum amylase which occasionally occurred following mumps was also cited as an example of infectious etiology. But by and large infection has been relegated to a minor role.

Recently workers with the Coxsackie virus have reported an unusual development.¹⁷ The inoculation of the Conn.-5 strain of the Coxsackie virus into suckling mice produced extensive lesions throughout the animal. The same virus, however, when injected intraperitoneally or intracerebrally into adult mice consistently showed a pathologic affinity for the pancreas. The ingestion of infected animals by other mice produces pancreatic lesions but not with the same organ selectivity. Irrespective of the route of inoculation following the injection there develops a massive necrosis of acinar tissue.

This is followed by a marked cellular reaction with histiocytosis, a slight fibroblastic proliferation and finally replacement of glandular tissue by fat. The animal loses weight, its fat content is decreased and edema develops due to hypoproteinemia. There is no involvement of the islands of Langerhans or the pancreatic ducts. Where the disease has been severe the entire gland may be replaced by adipose tissue. Where the involvement is less virulent, scattered islands of normal pancreatic tissue remain which later exhibit hypertrophy of the acinar cells. Scattered throughout the mesen-

*Serum fat content in mg. per cent equals 28.3 times the fatty acid content in m.Eq. per liter (28.3 is the conversion factor).

tery there may be areas of fat necrosis which later undergo calcification.

The virus multiplies in pancreatic tissue and can be passed from one animal to another. The pancreatic lesions have been found to be a specific effect of the virus; when the virus is neutralized with anti-sera the mouse is completely protected.

Thus far no correlation has been drawn between this experimentally produced disease and pancreatitis in the human. However, there is a condition that has been described in some children in which replacement of the entire pancreatic tissue by fat has occurred.¹⁸ This is similar to the complete replacement of the gland in the experimental animal.

CONCLUSIONS

OBSTRUCTION to external pancreatic secretion remains one of the most common findings to

explain the pathogenesis of pancreatitis. However, regurgitation of bile is not a necessary precursor for its development.

Metabolic disorders and protein deficiency appear to be specific factors in the etiology of pancreatitis. Ethionine, a metabolic antagonist of methionine, causes pancreatic lesions in the experimental animal almost identical to that found in the human. Alcoholism, because of the nutritional aspects or toxic factors involved, occupies an increasingly important position in the pathogenesis of this disease.

Coxsackie virus inoculated into adult mice produces a selective pancreatitis in which fat necrosis is a prominent feature.

It is quite likely that acute and chronic relapsing pancreatitis are produced by a number of different etiologic agents and that the two diseases while related, are more frequently of diverse etiology.

405 State Street

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M. H. HOLLAND, M.D.

Weebawken

Clinical Studies with a New Modified Cod Liver Oil Lotion*

In treating inflammatory dermatitis, a simple cod liver oil lotion was found effective and avoided the dangers of undesirable side-effects.

IN NOVEMBER 1952 the results of treating 100 cases of various forms of inflammatory dermatitis with a new soothing cod liver oil lotion were reported. This paper¹ deplored the use of topical medication in which sensitizing agents were incorporated.

According to this observer, some of the agents most frequently responsible for cutaneous sensitization reactions are the topical anesthetics such as the "caine group" (benzocaine for example) and the topically applied antihistamines. The latter, according to Lehmann,² act as local anesthetics, to which they are closely related chemically, and not as antihistamines.

Despite the warnings sounded by many authorities, including Lane,³ Pillsbury,⁴ Osborne⁵ and Peck,⁶ pointing out the dangers from these so-called healing applications, the incidence of sensitization reactions, iatrogenic eczema and therapeutic or "overtreatment dermatitis"⁵ appears to continue unabated. Indeed, the Council on Pharmacy and Chemistry of the American Medical Association recently voted "to discontinue the acceptance of dermatological preparations of all antihistamine drugs—".⁷

* Desitin® lotion, kindly supplied by the Desitin Chemical Company, Providence, Rhode Island.

THE results obtained in treating 200 additional cases of commonly encountered dermatitis with a bland, non-sensitizing lotion containing only the most basic ingredients such as zinc oxide, lime water, magnesium carbonate, glycerin, cod liver oil, etc., are presented here. The presently used lotion also contains some perfume, emulsifying and bacteriostatic agents (Tween, Span, Parasept) and an antioxidant, propyl gallate. None of these proved sensitizing. How satisfactory this simple lotion was can be seen from the following cases.

CASE REPORTS

No. 1. T. R., female, age 3, was seen because of a severe eczematoid contact dermatitis of the face, neck, ears, and chest of three weeks' duration. History indicated that the child had used an antihistamine cream for a recurrent mild eruption of the neck (probably intertrigo) intermittently for over three months.

Three weeks before the present examination the application of the antihistamine was followed within eight to ten hours by a severe topical reaction with erythema, swelling, superficial vesiculation and exudation. Wet dressings with diluted Burow's solution and Desitin® lotion produced healing within two weeks. A subsequent patch test with the suspected antihistamine cream was positive.

No. 2. J. K., male, age 55, was examined because of a severe exudative dermatitis of the geni-

talia and groin of seven days' duration. He had applied an antihistamine lotion for the third time in the past year. Almost immediately following this he experienced a "burning sensation and swelling" of the skin of the perineal area. This was followed by extreme discomfort and itching. Wet dressings with Burow's solution (1:20) and the application of Desitin® lotion effected complete healing in about ten days. A subsequent patch test with the antihistamine used was positive.

TABLE 1 summarizes the results obtained with Desitin® lotion. The clinical criteria are defined as follows: improved—definite lessening of signs and symptoms; greatly improved—almost complete relief of symptoms and disappearance of signs; healed—complete relief of symptoms and disappearance of signs; aggravated—increase in either symptoms or signs regardless of degree; unimproved—no change.

In six cases of neurodermatitis, one and one-half to three per cent of liquor carbonis detergens was added with favorable response as noted by Grayzel, *et al.*⁸

The results were gratifying in that there were no undesirable side reactions of either sensitization or primary irritation. Healing was induced rapidly and effectively. Cosmetically, the lotion was most agreeable and practicable, eliminating complaints about soiling of linen, odor, excessive oiliness or extreme dryness.

Further it was found easy to apply and just as simple to remove.

TABLE 1. RESULTS WITH DESITIN® LOTION

	Improved	Greatly Improved	Entirely Cleared	Aggravated	Unimproved
Exudative					
Eczema	10	28	12	1	1
Dermatitis					
Medicamentosa	1	12	3	0	
Dermatitis					
Venenata	2	40	51	1	2
Intertrigo	3	2	3	0	
Atopic					
Dermatitis	3	2		0	
Pityriasis					
Rosea	1	6		0	
Lichen Planus	2	3		0	
Hemostatic					
Eczema	1	4		0	
Neuro-					
dermatitis	1	3	2	0	

SUMMARY

A STUDY of two hundred cases of dermatitis treated with an improved form of cod liver oil lotion is reported.

The modified lotion contained some of the newer wetting agents and a volatile essence which made for a smoother, more homogeneous lotion without appreciable cod liver oil odor and for ease of application and removal.

The results were as uniformly free from adverse side reactions as they were effective.

Favorable response in neurodermatitis was obtained by the use of the lotion plus one and one-half to three per cent liquor carbonis detergens. The addition of other active ingredients to the lotion does not impair its emollient and soothing qualities.

2412 Palisade Avenue

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Trustees' Meetings

April 4, 1954

(Minutes Approved May 16, 1954)

A REGULAR meeting of the Board of Trustees was held on Sunday, April 4, 1954, at the Executive Offices, Trenton. The following is a summary of the principal actions taken at this meeting:

A motion was adopted officially authenticating a vote of the Board, obtained by mail, opposing the proposed inclusion of chiropodists under Medical-Surgical Plan.

The personnel of the Veterans Medical Services Committee, established by the Board at its meeting on January 10, was announced by the chairman as follows: Dr. Harrold A. Murray, chairman; Dr. C. Byron Blaisdell and Dr. Albert B. Kump, Dr. Irving P. Borsher was named to the committee.

In conformity with the decision of the Board, at its meeting January 10, to send representatives from The Medical Society of New Jersey to the New Jersey Council of Professions, it was agreed that the delegates should consist of a member of the State Board of Medical Examiners and the chairmen of the four subcommittees to the Welfare Committee.

Approval was given to the appointment of Dr. H. Wesley Jack, chairman of the Advisory Committee on Cancer Control, as the representative of The Medical Society of New Jersey to the Campaign Coordinating Committee for the annual cancer crusade next April, to be conducted by the New Jersey Division of the American Cancer Society.

A request that The Medical Society of New Jersey co-sponsor the 1954 Workshop in Health Education of the New Jersey Tuberculosis League, to be held at State Teachers College, Trenton, June 14-25, was granted.

Approval was given to the nomination of Dr. Harrold A. Murray and Dr. Sigurd W. Johnsen as representatives of the Medical Society qualified to serve as directors of the Associated Hospital Service of New York, in compliance with a request submitted by that organization.

In response to the suggestion that representatives from Hospital Service Plan of New Jersey be invited to be present at the annual meeting in May, to be available for discussion concerning Hospital Service Plan in conjunc-

tion with the sessions of the House of Delegates, the Board approved the extension of such invitation to Mr. Sorg and Mr. Durgoni, president and executive director respectively of the Hospital Service Plan of New Jersey.

A MOTION was adopted authorizing the establishment of a liaison committee between The Medical Society of New Jersey and the New Jersey State Nurses' Association.

The Board granted approval to the proposal of President Decker that The Medical Society of New Jersey sponsor a joint dinner meeting to which would be invited the members of the liaison committees of the Society for the discussion of joint problems and concerns.

In response to a letter from the chairman of the Blood Bank Committee of the New Jersey Society of Clinical Pathologists requesting the appointment of two members from the Medical Society for one-year terms on the Blood Bank Commission, in accordance with the 1953 action of the House of Delegates approving the establishment of such commission, the Board authorized the president and chairman to make such appointment.

In order to expedite the business of the House of Delegates, official approval was given to the suggestion made by Dr. Decker that the component county medical societies be requested to submit to the Executive Offices, on or before May 12, 1954, copies of resolutions intended for introduction in the first session of the House of Delegates, such resolutions to be submitted on official forms to be made available to the county societies.

Approval was granted to the listing of the Medical Society as co-sponsor of a project dealing with accident prevention among infants and preschool children, in conformity with a request originating with the State Department of Health.

THE Board was informed by Dr. Greifinger, secretary to the Society that individual hospitals are requesting staff physicians to send ambulatory patients to departments in the hospitals for treatment and are collecting charges for such treatments. The Board recorded its

disapproval of such procedure by reaffirming its action of January 11, 1948:

"That the sending of ambulatory private patients to hospitals for x-rays, laboratory examinations, or physical therapy treatment be discouraged where adequate facilities are available in private physicians' offices. Nothing in this recommendation should be interpreted as interference with existing public health studies, mass x-rays or studies, or clinic care of the indigent."

The Board agreed to the suggestion that personal contact by a committee of the Society should be made with the governing boards of hospitals involved. Dr. Harrold A. Murray, Dr. Marcus H. Greifinger, and Dr. Royal A. Schaaf were chosen to constitute such a committee.

After protracted discussion concerning the feasibility and desirability of holding a cruise-convention in 1955, the Board agreed not to approve the proposal.

Dr. Vincent P. Butler was nominated by the Board for re-election to the Board of Trustees of Hospital Service Plan of New Jersey as a representative of The Medical Society of New Jersey, for the term of one year.

The Board adopted a motion, in response to a request submitted by the Medical-Surgical Plan of New Jersey, approving the postponement of the date for final decision regarding the status of certain proprietary hospitals from May 1, 1954 to November 1, 1954.

Approval was granted to a request made by Dr. Lance, president-elect, for permission to effect changes in committee organization and administrative procedure in the interest of increased efficiency and dispatch in the conduct of the Society's business during the term of his presidency.

May 16, 1954
(Minutes Approved June 6, 1954)

A REGULAR meeting of the Board of Trustees was held on Sunday, May 16, 1954, at Haddon Hall, Atlantic City. The following is a summary of the principal actions taken at this meeting:

Board approval was granted to the president's action accepting the invitation for the Society to jointly sponsor, with the State Department of Health, the 1954-55 Diabetes Detection Drive, and the appointment of Dr. George M. Knowles as the Society's representative on the Planning Committee.

A motion was adopted accepting the invitation for The Medical Society of New Jersey to become a sponsor of the New Jersey State Conference on Citizenship, to be held at Rutgers University on October 9, 1954.

A motion was adopted authorizing that the Medical Society accept membership in the National Society for Medical Research.

Approval was given to the program of the New Jersey State Safety Council to effect a reduction in traffic accidents and to achieve a firm and fair enforcement of traffic regulations in New Jersey.

The Board adopted motions of commendation and thanks to Dr. Henry B. Decker, retiring as president of The Medical Society of New Jersey, and Dr. Reuben L. Sharp, retiring as chairman of the Board of Trustees, for the generous and excellent service which they rendered to the Society during their terms of office.

A motion was adopted granting approval of the renewal of the Veterans Administration contract for the year beginning July 1, 1954 and ending June 30, 1955, pending consideration of the revised fee schedule submitted by the Medical Society on May 1, 1953.

Free Medications for Cancer Patients

Under the service program of the American Cancer Society, New Jersey Division, certain medications are furnished (at the direction of physicians) without cost to indigent and medically indigent cancer patients. They are obtainable through the county chapters of the Society. The following free medications have been approved by the State Executive Committee for cancer patients:

Demerol®	Morphine
Nitrogen Mustard	Codeine
Penicillin and other	Radon Ointment
Mycetins	Methyl Androstendiol
Estranol	Testosterone
Stilbestrol	Depo Testosterone

Physicians desiring further information about medications should write to the county chapter of the American Cancer Society or to the New Jersey Division, 9 Clinton Street, Newark 2, N. J.

Appraising Polio Vaccine

More than 600,000 children have completed three inoculations, in the field test of the trial polio vaccine developed by Dr. Jonas E. Salk of the University of Pittsburgh. Emphasis now shifts to the evaluation study. The validity of the evaluation is dependent upon data gathered on poliomyelitis cases in the test groups, including those children in the first three grades who did not get vaccine.

Data on cases among family members of participating children are an integral part of the study. Since the number of poliomyelitis cases among the test groups may not be large, it is essential that *all* cases are completely reported. Early diagnosis, prompt reporting and follow-up, and the securing of necessary epidemiologic information and laboratory specimens are important factors in the evaluation.

An outline of procedures and copies of necessary forms have been sent to local and state health authorities. It is important that physicians in areas where vaccinations were not given, cooperate by notifying health officers of cases occurring among children who participated in the trials and then migrated to other areas and children who go to summer camps. Local health officials also need information on participating children who receive injections of gamma globulin. This phase of the study will depend, to a large degree, on the wholehearted cooperation of practicing physicians.

For information on how *you* may participate write to Hart Van Riper, M.D., Medical Director of the National Foundation at 120 Broadway, New York 5, N. Y.

Obituaries • • •

DR. CHARLES H. MITCHELL

Dr. Charles H. Mitchell, former Mercer County Republican county chairman and county physician for 28 years, died on June 11 at the age of 76.

Dr. Mitchell was graduated from the University of Pennsylvania Medical School in 1900. He entered political life at the same time he began his medical practice in Trenton. He retired from active politics in 1939, but continued on as county physician until 1951.

Dr. Mitchell was a veteran of the first world war, and was a member of several local fraternal organizations.

DR. ANTHONY P. VERNAGLIA

Dr. Anthony P. Vernaglia of Hawthorne, died on June 8 in Germany, while vacationing with his family.

Dr. Vernaglia was born in New York City in

1904, and received his medical degree from the University of Maryland School of Medicine in 1928. He was head anesthetist at the Paterson General Hospital for the last ten years, and was a member of the American Society of Anesthesiologists.

DR. BENJAMIN WITKOFF

Dr. Benjamin Witkoff of Hasbrouck Heights, died in a car-train collision on June 28.

Dr. Witkoff was born in 1900. He was graduated from the Eclectic Medical College of Cincinnati in 1928. Before studying medicine he was a professional violinist and had given concerts in Cincinnati. He was a member of the Bergen County Symphony Orchestra.

Dr. Witkoff was a member of the staffs of Hackensack and Hasbrouck Heights Hospitals, and was attending physician for the local health board.

Announcements • • •

New Jersey Cancer Seminar

The Annual Cancer Seminar of the American Cancer Society, New Jersey Division, will be held at Hotel President, Atlantic City, on Saturday and Sunday, October 16 and 17, 1954.

Details are now being arranged by the Professional Information Committee of the division of which Dr. Joseph I. Echikson of Newark is chairman.

Management of Infections

"The Management of Infections" is the subject of the 27th Annual Graduate Fortnight of the New York Academy of Medicine. Fee for the entire two-weeks course is \$10. For either single week the fee is \$6. The course begins on October 18, 1954. For details, write to Committee on Medical Education, Academy of Medicine, 2 East 103 St., New York 29, N. Y.

Chest Disease Course

The American College of Chest Physicians, in cooperation with the state chapters of the College and staffs of local hospitals and medical schools, will sponsor the Ninth Postgraduate Course on Diseases of the Chest at the Hotel Knickerbocker, Chicago, October 18 to 22, 1954; and the Seventh Annual Postgraduate Course on Diseases of the Chest at the Hotel New Yorker, New York City, November 8 to 12, 1954. These courses bring physicians up to date on recent advancements in heart and lung diseases. Tuition for each course is \$75.

Further information may be secured from the American College of Chest Physicians, 112 East Chestnut Street, Chicago 11.

Occupational Therapy Convention

The Conference of the American Occupational Therapy Association will be held at the Shoreham Hotel, Washington, D. C., October 16 to 22, 1954. Further details may be obtained from the Association at 33 West 42nd Street, New York 36, N. Y.

Occupational Medicine Symposium

Columbia University announces lectures on Occupational Medicine from nine to ten o'clock on Saturday mornings beginning on September 18, 1954. The lectures will be given in Amphitheater I, 630 West 168th Street, New York 32, New York. The lecturers will be members of the staff of the School of Public Health. There is no formal registration and no tuition fee. The schedule is as follows:

1954

September 18—Scope and Objectives of Occupational Medicine

September 25—Industrial Toxicology

October 2—Toxic Metals I

October 9—Toxic Metals II

October 16—Toxic Solvents I

October 23—Toxic Solvents II

October 30—Toxic Dusts

November 6—Toxic Gases

November 13—Ventilation, lighting and noise

November 20—Nuclear physics and radiation hazards

All lectures are at 9 a.m.

Cardiovascular Course

A course in "Newer Developments in Cardiovascular Diseases" will be given at The Mount Sinai Hospital, New York, October 11 through 15, 1954, under the auspices of the American College of Physicians. Dr. Arthur M. Master and Dr. Charles K. Friedberg will direct the course and prominent cardiologists and cardiac surgeons will participate. For details, write to Dr. Arthur Master at Mt. Sinai Hospital, 2 East 100 St., New York 29, N. Y.

Geriatric Symposium

The American Geriatric Society announces a Symposium on Geriatric Medicine at the Roosevelt Hotel, New York City, November 12 and 13, 1954. Distinguished specialists from leading medical schools and teaching hospitals will conduct the symposium. All physicians are invited to attend this important symposium. There is no registration fee. For full program, write to Dr. Edward Henderson at 236 Midland Avenue, Montclair, N. J.

Academy of Psychosomatic Medicine

The Academy of Psychosomatic Medicine meets at the Plaza Hotel in New York City on October 8 and 9, 1954. This year's theme is *Psychosomatic Aspects of Surgery*. Papers cover such topics as: Psychosomatic aspects of anesthesia; general surgery, gynecologic surgery; plastic, otolaryngologic and oral surgery; mutilating operations; endoscopic surgery; orthopedic surgery; eye surgery; pediatric and neurologic surgery. There are a few vacancies on the program. Those interested in presenting papers should write to Dr. Benjamin Raginsky, 376 Redfern Ave., Montreal, P. Q., Canada, stating their special interest.

Applications for fellowship should be submitted to Dr. Ethan Allan Brown, 75 Bay State Road, Boston 15, Mass.

International Congress of Cardiology

An International Congress of Cardiology will be held in Washington, D.C., September 12 to 15. It will be immediately followed by the annual scientific sessions of the American Heart Association. Opening session will be at Constitution Hall, 10:30 a.m., Sunday, September 12, 1954.

The scientific sessions, lasting three days, will include formal papers, panel discussions, clinicopathologic conferences and visits to important medical centers in Washington and Bethesda. The program will be printed in French, Spanish and English. Immediate translation of some of the papers and discussions will be made in the three languages.

Subsequent visits and conferences to twenty leading cardiac clinics in different parts of the U. S. and Canada have been arranged.

Arthritis Research Fellowships

Research Fellowships are now available for basic investigation related to arthritis. The predoctoral Fellowship carries a stipend up to \$3,000. Postdoctoral Fellowships range from \$4,000 to \$6,000 a year. More experienced investigators may be interested in senior Fellowships which carry stipends up to \$7,500 and which are tenable for five years. Deadline for application is October 15, 1954. For information and application forms, write to Arthritis Foundation, 23 West 45 Street, New York 36, N. Y.

Proctology Fellowship

The International Academy of Proctology announces a Teaching and Research Fellowship in proctology under the direction of Dr. Marcus D. Kogel, Dean of the Albert Einstein College of Medicine, New York City. The Academy has voted a \$1,000 annual grant for each of three years to assist in the development of research and educational projects in proctology at the University.

The Academy also offers a Teaching Seminar, open to all physicians without fee. Research Fellowships in proctology are sponsored by the Academy, and three such Fellowships were voted at the time of the last Annual Meeting. Dr. Earl J. Halligan, Director of Surgery of the Jersey City Medical Center, and International Secretary-General of the Academy, is in charge of a Research Fellowship at the Jersey City Medical Center. Additional Fellowships were established in the mid-west and on the west coast.

Old Medical Journals Needed in India

The JOURNAL has been informed by St. George's Mission Hospital in India that the doctors there are in desperate need of old medical journals and also of medical books which have not become so old as to be obsolete. They will also be grateful for secondhand instruments and appliances.

Unfortunately they are in no position to pay for postage, so that any member who wishes to make a contribution of his old medical books, journals, or equipment, will also have to pay for the postage to India.

The material should be sent to St. George's Mission Hospital, Punalur, P. O. Travancore, S. India.

TB Vaccination Program in Hudson

Under the sponsorship of the B. S. Pollak Hospital for Chest Diseases a BCG vaccination program has been initiated for residents of Hudson County. The vaccination is limited to tuberculin negative reactors who are unavoidably exposed to tuberculosis at home or at work. The program is on a voluntary basis. This is said to be the first such organized BCG program on a county wide basis to be instituted in New Jersey.

Dr. Orton Heads Laryngologic Association

At the 75th Annual meeting of the American Laryngological Association this June, Dr. Henry B. Orton of Newark, N. J., was elected president. At the same time, Dr. Orton received the Newcomb Award for distinguished work in laryngological progress. Dr. Orton was awarded this honor on the basis of his pioneer work on surgery for malignant diseases of the larynx and neck.

Urology Award

The American Urological Association offers an annual award of \$1,000 (first prize of \$500, second prize \$300 and third prize \$200) for essays on the result of some clinical or laboratory research in urology. Competition is limited to urologists who have been graduated not more than ten years, and to residents and trainees in urology.

For full particulars write William P. Dindusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before January 1, 1955.

New Jersey Fellows—American College of Chest Physicians

At the annual meeting of the American College of Chest Physicians held recently in San Francisco the following New Jersey physicians were elected:

Dr. Irving W. Willner, Newark, to the Board of Regents.

Dr. Juan R. Herradora, Jersey City, to the Board of Governors.

Special Anthropological Journal

The American Anthropological Association announces that the August issue of the *American Anthropologist* has been devoted entirely to the American Southwest. Physicians will be interested in the analysis of the biological and anthropological culture of the American Southwest and in the way in which all the other human sciences have been integrated into a meaningful whole. Copies may be obtained from the American Anthropological Association at the University of Chicago, Chicago 37, Illinois.

Residencies Approved at East Orange VA Hospital

The Veterans Administration Hospital, East Orange, now has its own Medical Advisory Committee, the equivalent of a Dean's Committee. Chairman of this committee is Dr. Bernard J. Pisani of Englewood. The remainder of the committee consists of the following:

Dr. Lewis H. Loeser, Newark, N. J.
Dr. Allen O. Whipple, Princeton, N. J.
Dr. Stuart Z. Hawkes, Newark, N. J.
Dr. Stewart F. Alexander, Park Ridge, N. J.
Dr. John H. Keating, Hillsdale, N. J.
Dr. Henry H. Kessler, Newark, N. J.

In addition to advising and supervising the education and training program, the Medical Advisory Committee will advise on research, therapeutic agents and the appointment of consultants and attendings.

Under direction of the Medical Advisory Committee, a residency training program and other professional educational training is being launched at the Veterans Administration Hospital, East Orange. Residency training will be offered in the following specialties:

General Surgery	Anesthesiology
Otolaryngology	Urology
Orthopedics	Pathology
Neurology	Internal Medicine
Physical Medicine & Rehabilitation	Radiology

To meet the requirements of the American Boards, part of the training will be in collaboration or affiliation with a number of local hospitals and medical teaching institutions. The full-time staff is experienced in the field of teaching residents having been part of previous residency training programs in Veterans Administration hospitals in Brooklyn, Bronx, and Staten Island, New York; Martinsburg, West Virginia; and New Orleans, Louisiana.

Most of the members of the full-time staff are certified by American Boards.

Dr. J. A. Rosenkrantz, Chief, Professional Services, Veterans Administration Hospital, East Orange, is the administrative officer in charge of the residency training program.

Prize for Anesthesiology Essay

The Rhode Island Medical Society announces that a cash prize of \$250 is offered for the best essay on modern developments in anesthesia. The dissertation must be less than 10,000 words. For more details write to Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, R. I.

County Society Reports • • •

Cumberland

A meeting of the *Cumberland County Medical Society* was held on July 13 at Palatine Lake. The meeting was under the chairmanship of Dr. Frank J. T. Aitken, its president.

Dr. Albert B. Kump of Bridgeton is now Second Vice-President of The Medical Society of New Jersey and Dr. Carl N. Ware of Shiloh is a member of the Board of Trustees of The Medical Society of New Jersey.

During the meeting, applications for membership from Dr. Edward J. Chmielewski of Millville and Dr. Milton Fineman of Vineland were considered.

Following the short business meeting an excellent dinner was served.

GEORGE R. RISI, M.D.
Reporter

Middlesex

The annual combined *Middlesex County Medical and Dental Societies* outing was held at the Metuchen Country Club on June 16.

Afternoon activities consisted of golf and other outdoor sports. All present were served clams and beer. Participants then went to the Oak Hills Manor where they were joined by other members of both societies. Cocktails were served. This was followed by an excellent steak and lobster dinner.

Everyone who attended received a door prize and a gift at the table. Those who won in the golf tournament also received prizes. The prizes were donated by business men, pharmacists and medical and dental supply houses.

The entertainment was furnished by an excellent after-dinner speaker—Doctor Murray Banks of New York City—who charmed and amused everyone, and who spoke some words of wisdom.

All in all it was an excellent outing and everyone seemed to have had a wonderful time.

IVAN B. SMITH, M.D.
Reporter

Monmouth

The annual outing of the *Monmouth County Medical Society* was held at the Homestead Golf Club, Spring Lake, on June 23, under the general chairmanship of Dr. Morton F. Trippe.

Dr. Joel Feldman, by winning first place in the

afternoon golf tournament for the sixth time, retained the Society Cup as his permanent possession and also won the Annual Steadman Cup. Second place award went to Dr. Joseph Bossone, and third place to Dr. Norman Nathanson.

At the evening dinner meeting Dr. George McDonnell, the out-going president, thanked the members for their cooperation during his term of office, and presented a report on the recent immunization program for poliomyelitis. Dr. Howard Pieper, the incoming president, presented Dr. McDonnell with a gavel as a token of appreciation from the Society for the splendid job that he had performed.

The following were elected to full membership: Drs. Forman Bailey, Ocean Grove, and Willard R. Dill, Asbury Park, Drs. Dean Coddington, Red Bank, George F. Cowling, Keyport, and M. Leonard Genova, Keansburg, were elected to associate membership.

Among the honored guests, were the following: Col. Otto Churney, Post Surgeon of Fort Monmouth, Robert Rankin, D.D.S., President of the Monmouth County Dental Society, and William Folgelson, President of the Monmouth-Ocean County Pharmaceutical Society.

DONALD W. BOWNE, M.D.
Reporter

Union

The annual meeting of the *Union County Medical Society* was held at the White Laboratories on May 12 with the members as guests of the Laboratories' management for dinner.

The following officers were elected for one year: *President*, Edward G. Bourns; *President-Elect*, Carl G. Hanson; *First Vice-President*, Paul J. Kreutz; *Second Vice-President*, Thomas S. P. Fitch; *Secretary*, Nathan S. Deutsch; *Treasurer*, Henri E. Abel; *Reporter*, Merton L. Griswold, Jr.

Dr. Bourns then accepted the chair from the retiring president, Dr. McCallion, after a presidential address.

Candidates unanimously elected to membership in the society were: Dr. Joseph A. Cipolla, Fanwood and Dr. Anthony M. Spirito, Elizabeth.

Discussion centered around the division of surgical fees by the Medical-Surgical Plan, and resolutions on proposed federal legislation pertaining to the practice of medicine.

MERTON L. GRISWOLD, JR., M.D.
Reporter

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Sandoz Atlas of Haematology. Compiled by Dr. E. Undritz, Sandoz Pharmacological Research Laboratories, under the direction of Professor E. Rothlin (translated into English by Dr. A. M. Woolman). Pp. 91 (with forty-four full color plates and explanatory text). Basle, Switzerland. Sandoz, Ltd., 1952. (\$7.00)

Students of blood diseases will find this atlas one of the finest and most comprehensive available. Recently translated into English (1954), its list of contributors reads like a Who's Who of hematologists. Although the majority of authors are European (particularly Swiss), authorities from the United States, South America and England are listed.

Because of its international flavor, great stress is placed on accurate terminology. For instance, the term "segmented" is preferred to "polynuclear," since neutrophils possess only one nucleus. Similarly, the term myelogenous is preferred to myeloid as the latter, strictly speaking, means "resembling marrow" and not "derived from marrow." Examples such as these will indicate the care taken to devise a system of terminology that is accurate, internationally understandable and semantically correct.

Extensive coverage is given to the development of normal blood cells, their function and destruction. This is followed by a section describing blood cells under abnormal conditions classified as constitutional or inherited anomalies, reactive changes and primary changes in the blood system itself. Blood disorders are given names of universal comprehension instead of eponyms. For example, sickle cell anomaly is called drepanocytosis. However, for those interested in eponyms there are some rare diseases such as Pelger-Huet's anomaly, Alder's anomaly and May-Hegglin's polyphylic disturbance of maturation.

Following this detailed discussion of the development of cells in normal and abnormal form there is a section devoted to the technical aspects of examining the blood and bone marrow. The stains commonly used are described in detail. Forms are suggested for recording the results of blood and bone marrow examinations. This is followed by a table of normal values for blood and bone marrow findings. Finally there is a table of the normal chemical constituents of blood and tables for the identification of mature and immature cells in the peripheral blood stream.

For the physician less interested in the finer points of hematology, the meat of this book is to be found in part 3, the illustrated section with explanatory notes. Here magnificently colored and enlarged microphotographs show pictorially all the cells found in normal and abnormal blood and bone

marrows. The entire red cell system including such unusual features as Heinz-Ehrlich bodies and Howell-Jolly bodies is illustrated. Plate 6 shows an interesting illustration of mitosis of normoblasts. Megaloblasts and megalocytes, the characteristic red cells of pernicious anemia, are shown in plate 7.

All the normal and abnormal forms of leucocytes are illustrated in the next series of colored photos and these are followed by illustration of the platelet system. Pictures of the so-called "L. E." cells are shown in plate 33. Subsequent plates illustrate non-hemopoietic elements of the bone marrow including osteoblasts, cells from tumor metastases. Finally, blood parasites are shown in the last group of figures.

This atlas will serve as an encyclopedia of blood diseases for the specializing hematologist and an illustrated guide to the physician who is occasionally called upon to examine a blood or marrow smear. It is published in a loose leaf note book format so that additions can be made readily as new material is published. It should be on the bookshelf of every clinical laboratory and every physician interested in diseases of the blood.

R. D. GOODMAN, M.D.

Doctor At Sea. By Gordon Ostlere, M.D. (Richard Gordon, pseud.) New York, Harcourt, Brace and Company, c1954. (\$3.00)

Attracted by the favorable review in this journal, I read this author's preceding book, "Doctor in the House." It was delightful, so, with much anticipation, I read "Doctor at Sea." It is not nearly as good. The humor, which bubbles spontaneously in Dr. Gordon's first book, falls flat and seems forced in many pages of this sequel.

This is the story of a young British doctor who displays a marked allergic reaction to his forthcoming marriage. He is advised by his psychiatrist to get away from it all; so he becomes a ship's surgeon on an old tramp steamer. The characters on the boat are a little too "stock" and the adventures in port are a little too gay. Nevertheless, here and there, the book is readable and mildly entertaining.

FRANK L. ROSEN, M.D.

The Jealous Child. By Edward Podolsky, M.D. Pp. 147. New York, The Philosophical Library, 1954. (\$3.75)

The title of this book is somewhat misleading. Of its 147 pages, only 25 or 30 are devoted to the jealous child. The rest of the chapters touch on disturbances due to physical defect, illegitimacy,

minority status, left-handedness, rejection and so on. The suggestions are, for the most part, pious platitudes. For example, the entire prescription for the jealous child is given in the form of eight rules: don't rush; wise actions are based on facts; seek out the simplest explanations first; try the simplest remedies first; handle each situation on its own merits; do not rush from one method to another; distinguish between the ostensible difficulty and the real one; and prevention is better than cure.

This is a fair sampling of the depth and wisdom of the book. However, many of the chapters contain nuggets of information, sometimes of shrewdness. The book is pitched at so low a level that it is obviously not intended for physicians, social workers, teachers or other professional readers. Presumably it is aimed at parents of below-average intelligence.

The book will be useful to the physician called on to give a lecture to certain types of parents' groups. Each chapter gives a few odds and ends which will help build a framework for a talk to an unsophisticated and uncritical audience.

HENRY A. DAVIDSON, M.D.

The Hepatic Circulation and Portal Hypertension.

By Charles G. Child, III, M.D., Professor of Surgery, Tufts College Medical School. From the Department of Surgery and the Laboratory of Surgical Research of the New York Hospital-Cornell Medical Center; in collaboration with Ward D. O'Sullivan, M.D. and others. Pp. 444. Phila., W. B. Saunders Co., 1954. (\$12.00)

The author reviews in great detail the histology and circulatory physiology of the liver, emphasizing recent contributions. From this background he offers a rational approach to the surgical treatment of diseases involving disturbances in portal circulation. He reviews the indications for and against portacaval shunt, splenorenal anastomosis, and the highly controversial hepatic artery ligation.

The material is presented from historical perspective, developing facts in progression to our present knowledge. The author has done considerable experimental and clinical work, in addition to presenting the experiences of others.

This book is of value to the internist who handles patients with liver disease and who would have a better understanding of diagnosis and treatment. To the surgeon it offers the background for future progress in the surgical management of liver disease.

HERBERT B. SILBERNER, M.D.

Modern Clinical Psychiatry. By Arthur P. Noyes, M.D., Superintendent, Norristown State Hospital, Norristown, Pennsylvania; Associate Professor of Psychiatry, Graduate School of Medicine, University of Pennsylvania. 4th ed. Pp. 609. Phila., W. B. Saunders Co., 1953. (\$7.00)

This 4th edition of *Modern Clinical Psychiatry* by Dr. Noyes is a very much improved and very up-

to-date volume. Ever since its original publication 20 years ago it has continued to increase in popularity, as well as in volume and in quality. It is refreshing to read the clear cut and succinct style of the author.

This edition consists of 36 well written chapters, with an adequate up-to-date bibliography following each chapter. As an example, there are 36 subject references in chapter 29 dealing with psychophysiology autonomic and visceral disorders.

The subject matter is clearly written so that the general practitioner will find this a particularly useful and informative volume. The trainee, too, will gather much help from the author's rich experience.

The chapters on personality development and structure, mental mechanisms and their functions, and psychotherapy are well covered, to mention but a few. The chapters dealing with child psychiatry, personality disorders and sociopathic personality disturbances, though brief, are adequate for the purposes of this manual. Such subject material is easily within the scope of several volumes and there must, of necessity, in a volume such as this, be limitations.

This reviewer endorses Dr. Noyes' book without hesitation. It should, without question, be in the library of every hospital.

CHARLES ENGLANDER, M.D.

Manual of Clinical Mycology. By Norman F. Conant, Ph.D., Professor of Mycology and Associate Professor of Bacteriology, Duke University School of Medicine; David Tillerson Smith, M.D., Professor of Bacteriology and Associate Professor of Medicine, Duke University School of Medicine; Roger Denio Baker, M.D., Chief, Laboratory Service, Veterans Administration Hospital, Durham, N. C.; Jasper Lamar Callaway, M.D., Professor of Dermatology and Syphilology, Duke University; and Donald Stover Martin, M.D., Chief, Bacteriology Section Communicable Disease Center, Chamblee, Georgia. New, 2d. Edition. 456 pages with 202 figures. Philadelphia and London, W. B. Saunders Company, 1954. (\$6.50)

Fungus diseases are on the increase. Some are becoming more widely distributed geographically; others are becoming more common since the introduction of antibiotics in the treatment of bacterial diseases. Some, such as coccidioidomycosis and histoplasmosis, are being recognized more frequently. This manual covers about all the physician needs to know in the practical every-day handling of these fungus diseases.

This new edition is written by the same group of experts who made the first edition so interesting and practical. The visceral or systemic fungus diseases are thoroughly covered, as well as the superficial fungus diseases of the skin, hair and nails seen in every day practice. New information is offered on standardized skin testing materials, staining and other diagnostic methods, epidemiology, and

immunology, as well as new advances in therapy. One of the book's great features is the excellence of the 202 highly informative illustrations. Of these, 88 are new.

As in its predecessor, this edition takes up each major mycotic disease in a separate chapter. Each disease is presented as to definition, geographic distribution, etiology, clinical signs, inoculation, pathology, immunology and treatment. Special references are given at the end of each chapter. Other chapters include the fundamentals of elementary mycology and the contaminants, which may be confused with the pathogenic fungi.

Any physician who encounters fungus diseases, whether they be the less complicated ringworm infections or the obscure systemic diseases of suspicious fungus origin, will find this book useful. To the dermatologist, internist, mycologist and pathologist, it offers a concise, accurate and up-to-date reference on mycology.

FREDERICK C. LICKS, M.D.

The American Sexual Tragedy. By Albert Ellis, Ph.D. Pp. 288. New York, Twayne Publishers, 1954. (\$4.50)

The project undertaken in this book is long overdue. There has long existed a need for appraisal of the sexual practice and attitudes of the people.

The need still exists! The author's thesis, in his own words, is: "The modern individual's general insecurities and feelings of inadequacy may be directly related to the sense of confidence that he originally gains or loses in the course of his early family experiences;—and may be indirectly related to general social conditions which influence his thinking and doing. But the modern woman's feelings of physical inadequacy largely stem from culture-centered and socially propagated influences which make it virtually impossible for any contemporary female, no matter how psychologically secure she may be, not to have a wide-ranging and deep-raging horror of several of her own physical attributes."

The author says: "Although it is easy to lay at the door of babytending or housekeeping woman's propensity for *not* producing any reasonable number of equivalents of *War and Peace*, or the *Ninth Symphony*, or the *Last Supper*, it may well be that her ceaseless expenditure of creativity in selecting and making her own clothing has some relevance in this connection." This is but one of the many examples of "reductio ad absurdum" by the use of extravagant hyperbole indulged in by the author. Multiple authorities are quoted, often sorrowfully out of context to prove distorted and tortured points.

I cannot but wonder at the scientific objectivity of the author who quotes his own writings to prove his points as Ellis does in several places.

The book jacket says: "Dr. Ellis speaks without false reticence." There is, however, a middle ground between prudery and pornography. The theories of the author would supplant our present social structures with a sexual anarchy. I can agree with the

author on one point—society does have a sexual problem—but the author's presented and implied solutions make me feel that his "treatment" is far more noxious than the disease. The book is without redeeming features.

DAVID J. FLICKER, M.D.

Handbook of Cardiology for Nurses. By Walter Modell, M.D., F.A.C.P., and Doris R. Schwartz, B.S., R.N. 2d ed. 320 pp. New York, Springer Publishing Co., Inc., 1954. (\$4.25)

The popularity of this book is evidenced by the appearance of this second edition within two years. The omission in the original treatise of the nurse's approach to the management of heart disease has been satisfied by the addition of another author and several new chapters.

The early sections of the book which explain anatomy, physiology and pathology as well as etiology, symptoms and signs of heart disease have been thoroughly revised. Much new information on drug therapy and anticoagulants has been added.

Five entirely new chapters deal with the total patient and his total nursing care from the hospital to the home. The nurse's functions as they deal with the care of the child and the adult with either acute or chronic heart disease are explicitly discussed.

This treatise is a gold mine of useful information about all phases of heart disease, its symptoms, its course and its treatment. It presents cardiology and nursing of the cardiac patient as a nurse must know it to do her work with skill and authority.

EDWARD C. KLEIN, JR., M.D.

Reconstructive Surgery of the Eyelids. By Wendell L. Hughes, M.D., F.A.C.S. 2d ed. Pp. 260. St. Louis, The C. V. Mosby Co., 1954. (\$8.50)

This book is an excellent historical review of all important plastic surgical procedures used in reconstruction of a part or all of the eyelids, and leads up to the author's methods of eyelid reconstruction.

The chapter of general considerations regarding grafting has been enlarged to include a more detailed description of types of dressing and methods of taking various types of free skin and mucous membrane grafts.

The author has written a new chapter on upper eyelid repair and reconstruction. This includes the author's methods of reconstructing a part or all of the upper eyelid.

There are two additional chapters, one on reconstruction of both lids and the second a short chapter on the choice of treatment for various types of growths on the eyelids.

There are about 300 drawings and illustrations and 458 references. All ophthalmologists and general plastic surgeons who do plastic surgery of the eyelid area should be familiar with this book.

ARTHUR E. SHERMAN, M.D.

TUBERCULOSIS *Abstracts*

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Tuberculosis in Children

By Edith M. Lincoln, M.D., *NTA Bulletin*, March, 1954.

Chemotherapy has been very useful in reducing the death rate from first infection, often called primary tuberculosis, in children. In many sections of the United States the death rate in children has always been low. Because good control of tuberculosis in adults has been established, there are relatively few active cases and consequently, few children are infected.

The effect of chemotherapy can best be judged in areas where formerly the death rate in children was high. Such a situation is found in the chest clinic of the Children's Medical Service of Bellevue Hospital, a large municipal hospital in New York City. Patients on this service come mainly from families of very low economic level, frequently receiving public assistance, and living in crowded conditions.

Twenty years ago one of every five children admitted to the tuberculosis ward of Bellevue Hospital died of the disease, usually within a year. Most of these children were first diagnosed in the hospital because a tuberculin test was part of the examination on admission. Of those who were admitted with the diagnosis of tuberculosis the great majority had originally been found by contact examinations or by tuberculin tests. The death rate in tuberculous children was unchanged until streptomycin became available late in 1946.

In tuberculous meningitis, which caused 60 per cent of the deaths from primary tuberculosis, the case fatality rate fell to 32 per cent between 1947 and 1951 after chemotherapy was employed. When isonicotinic acid derivatives were introduced in 1952, the case fatality rate was lowered

to about 12 per cent. Before chemotherapy tuberculous meningitis was 100 per cent fatal.

The use of antimicrobial therapy in other serious forms of tuberculosis has been even more effective. Since January 1, 1947, only one child at Bellevue Hospital has died of miliary tuberculosis, which until then was almost 100 per cent fatal, and only one baby died of tuberculous disease of the lung caused by local spread from the primary disease. Thus, in one hospital the case fatality rate from primary tuberculosis and its complications fell from over 20 per cent to 5.0 per cent after streptomycin and to 1.5 per cent after the introduction of isoniazid.

But mere survival is not enough. The great majority of the survivors from meningitis, after long convalescence, are leading normal lives, but a few show remains of the disease in partially paralyzed limbs or in diminished mental capacity. Such poor results seem to occur most often when the meningitis is not diagnosed and treated in an early stage. No one form of treatment will ensure complete recovery from tuberculous meningitis. The most important factors in success would seem to be an awareness of the possibility of tuberculosis and the recognition of the need for vigorous and prolonged therapy. A child with tuberculous meningitis diagnosed late is more likely to die, and if he recovers, is more likely to show evidence of damage due to the disease.

The importance of early diagnosis and prolonged treatment applies equally well to other forms of tuberculosis. A small cavity within a locally progressive primary tuberculosis of the lung without much evidence of pulmonary spread on X-ray will often heal under chemotherapy and remain well. On the other hand, chemotherapy

may save the life of a child with more extensive disease but at a later date surgery becomes necessary because a cavity or extensive scarring persists. Even when a complete cure is obtained the child has undergone years of hospital care which might have been avoided by earlier diagnosis of the pulmonary tuberculosis.

Chemotherapy is useful in other complications of primary tuberculosis. Sometimes in tuberculous disease of the bones or glands a sinus has been formed causing drainage through the skin. In such case almost magical results have been seen with specific therapy, with prompt closing of the sinus, often permitting surgery which would have been impossible without chemotherapy. In tuberculosis of the intestines the symptoms disappear quickly when the patient receives antimicrobial therapy. Many other forms of tuberculosis are also cured by appropriate chemotherapy.

In other complications of primary tuberculosis, such as disease of the bones, or of the lymph glands, it is hard to evaluate the results of chemotherapy, since such forms tend to be chronic and even without treatment have periods of spontaneous remission. Here again, when the complication is diagnosed before extensive damage is done, cure by chemotherapy or conservative treatment or both often results, whereas in late cases surgery is often required. In some forms of primary tuberculosis, notably in disease of the bronchi or endobronchial tuberculosis, so common in infants and young children, no form of chemotherapy so far devised has appeared to either alleviate symptoms or shorten the course of the disease.

No child should be operated on for a tuberculous complication without receiving chemotherapy during the period of surgery and for a few weeks thereafter. Indeed it may be said that because of the danger of spread of the tuberculous disease, no child with active tuberculosis should receive surgical treatment for any cause without coverage with antimicrobial therapy.

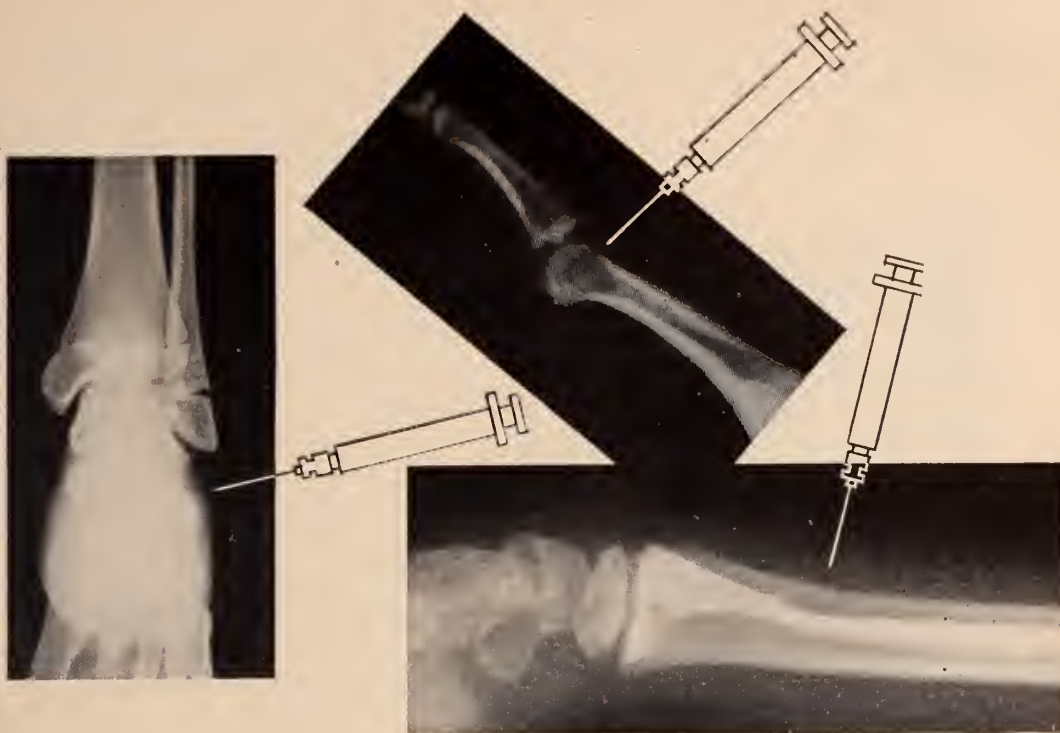
The question of the necessity for specific treat-

ment of uncomplicated asymptomatic primary tuberculosis is still under discussion. There was no reason for treating such cases with streptomycin. With the advent of isoniazid we have a different story. While again there seems to be no clear proof that the disease at the portal of entry is affected for the better, no one has reported a case of clinical meningitis developing in a patient who was receiving isoniazid. This is true even in individuals treated for miliary tuberculosis, a form of tuberculosis in which the meningitis rate has been reported as high as 70 per cent. If these observations can be substantiated, the use of isoniazid must be considered in every child with active primary tuberculosis and possibly in those with recent conversion of tuberculin tests even if chest X-rays are negative. Moreover, it will be necessary to treat with isoniazid for at least a year since it is known that meningitis is most apt to occur during this period. This will be a tremendous task and we should be sure of our facts before undertaking it.

The right way to prove the usefulness of isoniazid in the prevention of meningitis would be to follow a series of children with primary tuberculosis in which some cases are treated for a year and a similar control group is not treated, the selection of cases for each group being made arbitrarily. Such a study is now under way in Bellevue Hospital. Since the incidence rate of meningitis in primary tuberculosis is unknown, a large number of cases may be necessary to decide this important question.

If tuberculous meningitis and other serious complications can be prevented by the wider use of antimicrobial therapy, it will be a great step forward. But it will not eliminate the need for early diagnosis of every child infected with tubercle bacilli before complications occur. Widespread use of the tuberculin test in schools and hospitals and by private physicians is needed in order to promote early diagnosis of tuberculosis and augment the usefulness of chemotherapy in prevention as well as treatment.

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1. MacAusland, W. R., Jr.; Gartland, J. J., and Hallock, H.: The Use of Hyaluronidase in Orthopaedic Surgery, *J. Bone & Joint Surg.* 35-A:604 (July) 1953.

2. Swenson, S. A., Jr.: Minor Surgical Aspects of Closed Wounds, *Am. J. Surg.* 87:384 (March) 1954.

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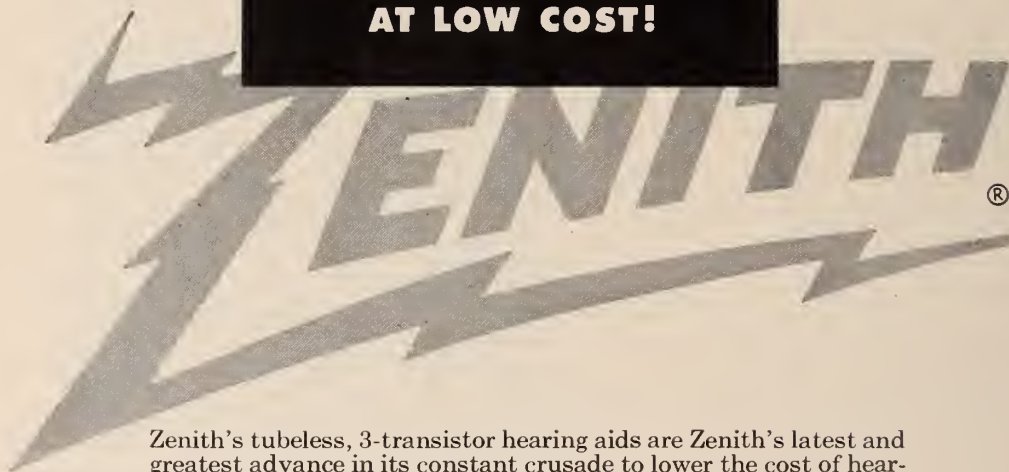
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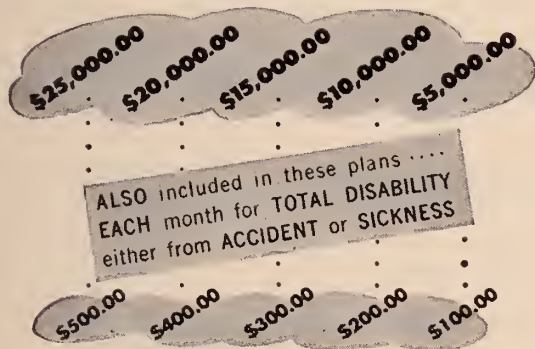
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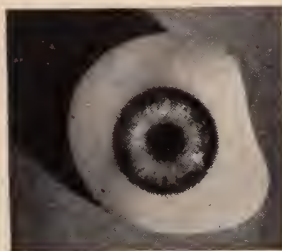
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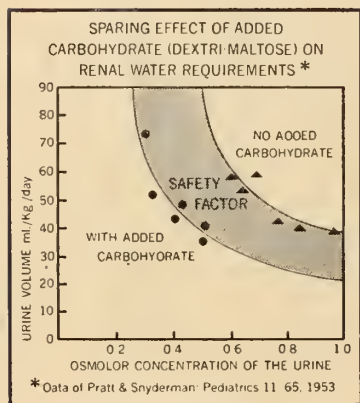
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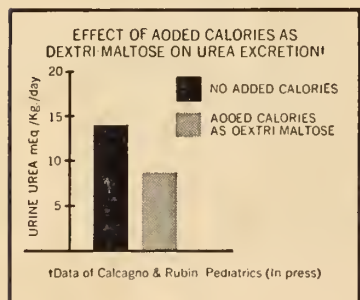
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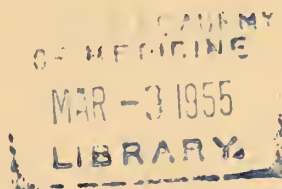
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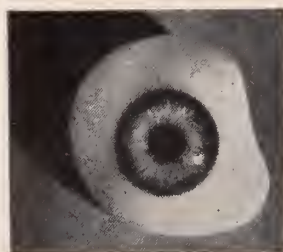
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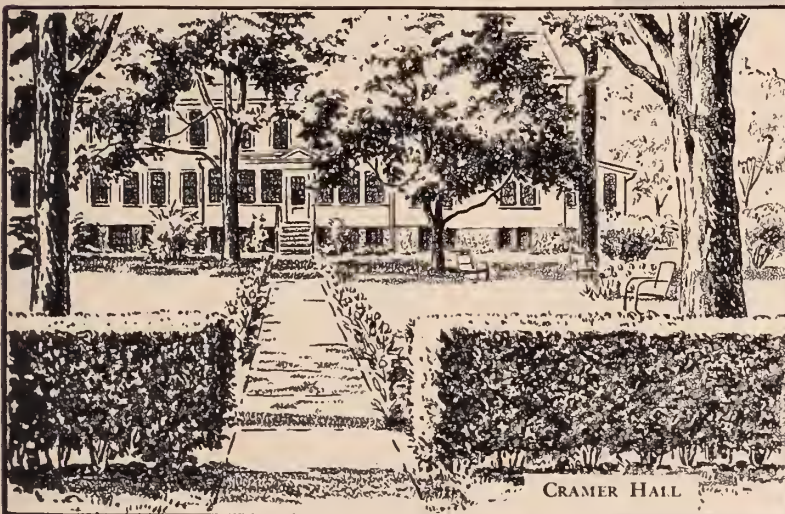
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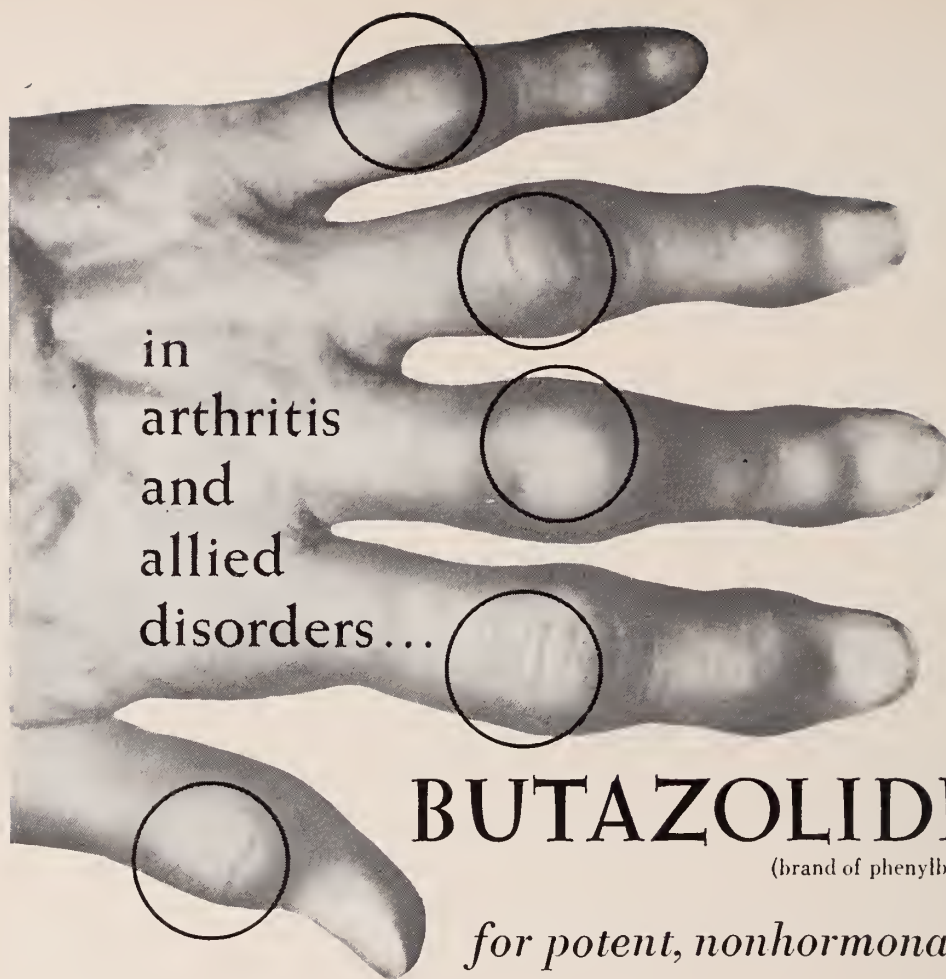
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*MacKnight, J. C.; Irby, R., and Toone, E. C., Jr.: *Geriatrics* 9:111 (Mar.) 1954.

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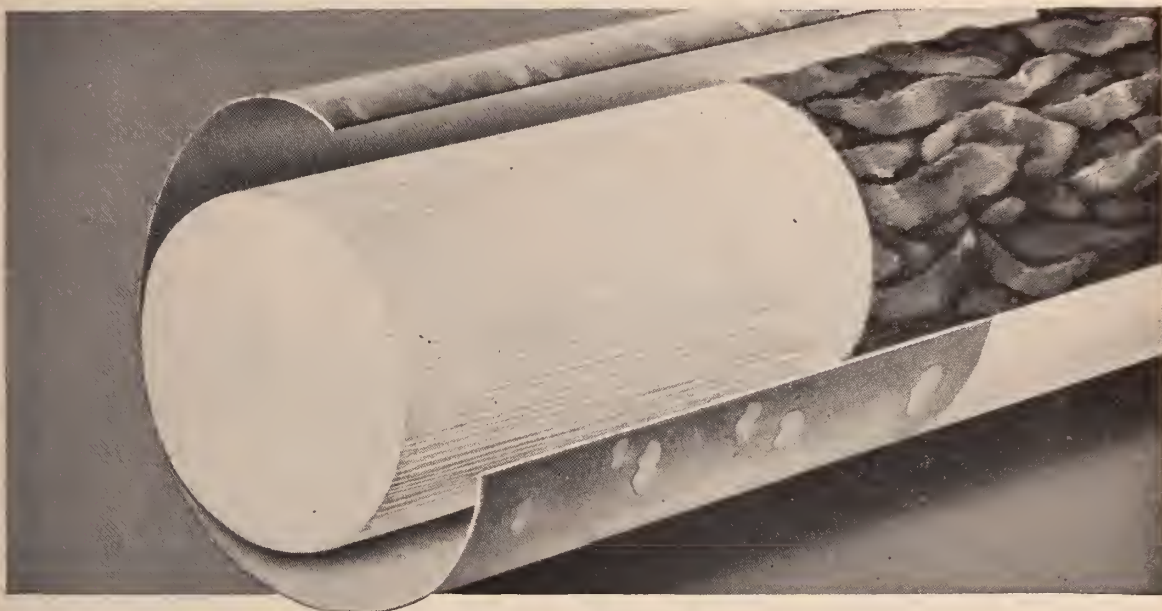


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		6	0	6	
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		<i>Cochlear damage % of patients</i>			
		Mild	Moderate	Total	
		0	0	0	
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*Heck, W.E.; Lynch, W.J., and Graves, H.L.: *Acta oto-laryng.* 43:416, 1953.

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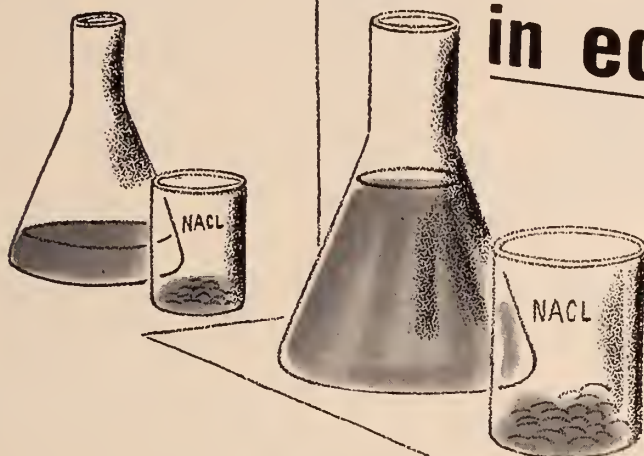
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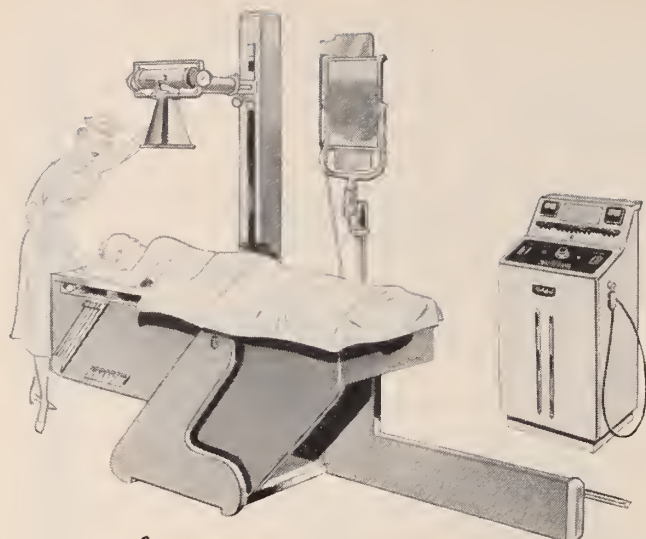
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2. Brown, W. E., and Sutherland, C. G.: Control of Edema in Pregnancy. *GP*, 8:65, Nov., 1953.



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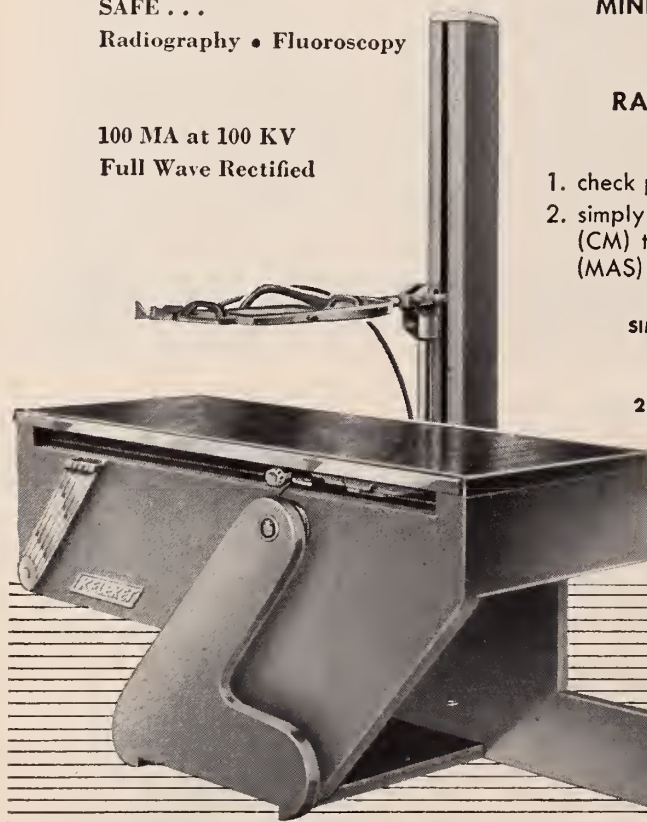
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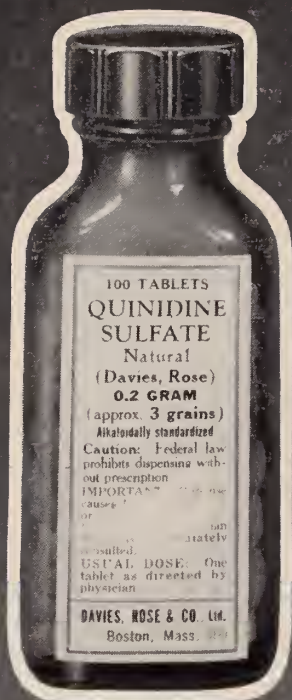


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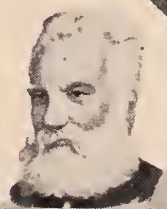
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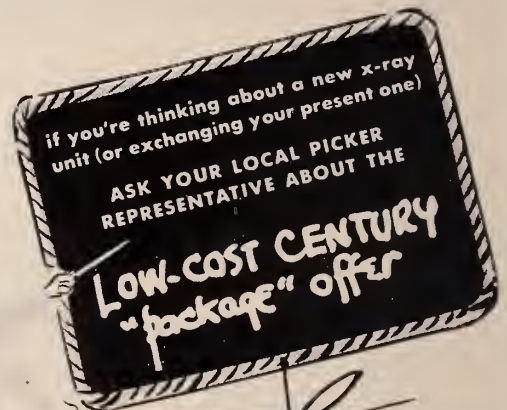
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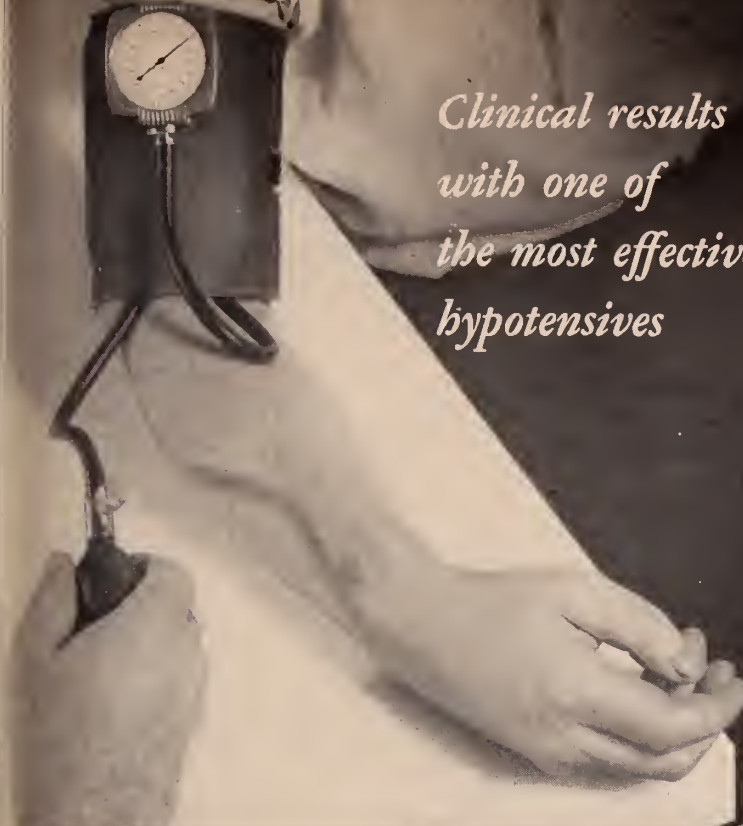
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Editorials • • •

Health Organizations and Collection Boxes

It is rare these days to come to a cashier's counter without seeing a cylindrical box with a slot in the top. Usually this is an appeal to give your spare change to a health organization. Ordinarily it is an organization that focuses on a specific disease.

It is hard to criticise such associations. They do good work, they help unfortunate victims of disease, their motives are pure. But if, in the long run, they are ineffective, it is only honest to face the fact.

Obviously they are in a scramble for the donor's dollar. There is only a certain amount of money to be pledged during a drive or a certain number of coins to be dropped down the slot. If the Podagra Society gets the dollar, the Association for the Relief of Insomnia is not going to get it. The field, to put it bluntly, is competitive.

What does determine the dollar distribution of donor's money? Certainly not the incidence of the disease, nor the amount of disability it causes, nor its cost to the country. The distribution is weighted by sentimental factors,

counterbalanced by the relative skills of the public relations people involved. A crippled child, for instance, is a more "appealing" picture than an old woman with diabetic pruritus. It is not surprising that organizations interested in the crippling diseases of children can attract more money than those interested in diabetes. Any doctor can multiply this example.

There is also an organizational as well as a scientific absurdity to the process. As it now stands, the voluntary health agency picture is analogous to what would happen if a city had a health department on Elm Street interested only in venereal disease. Three blocks down and around the corner on Linden Avenue is another city health department concerned with infant care. And in a loft over the firehouse is a third official city health department concentrating on tuberculosis control. Each department has its own commissioner, health officer and budget. And at the annual meeting of the board of aldermen the three health commissioners compete for their share of the city's welfare dollar.

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In his address* as retiring president of the Camden County Medical Society, Dr. Edwin R. Ristine pointed up this state of affairs. He urged "doctors to take the initiative in creating a central control committee to which all such groups would be accountable." In this way he hoped to create what he aptly calls "an expert, experienced realistic and eminently fair over-all consciousness to evaluate the relative importance of each of these groups in the health of the community."

The suggestion is long overdue. You cannot ask a special health association to give up its trademark and merge its identity with that of others. You must assume that certain wealthy persons who have been underwriting their pet agencies will withdraw support from a consolidated agency that, perhaps, might underemphasize the donor's special interest. So you cannot expect the agencies to consolidate on their own initiative. The physician is the logical leader in a movement towards fewer and better balanced health organizations.

Education as a Lien on Medical Practice

Tuition does not pay the cost of a medical student's education. Indeed the gap between the tuition bill and the actual cost is constantly growing. Many suggestions have been made for closing the gap: the medical education foundation, is one; solicitation of other gifts; Government assistance; higher tuition fees; help from corporations and so on. Each of these suggestions has something to be said for it; each has real defects.

And now comes Dr. Brian Bird, a Cleveland psychiatrist. He has a suggestion. If it costs \$5,000 to educate a medical student, and if he (or his father) pays only \$2,800 in tuition fees, why not bill the student for the deficit—in this example, \$2,200? Let him pay back the money within ten years after graduation. Suppose it were a legal obligation, based on a note which the student signed. Within ten years he would pay back \$2,200. That would mean \$220 a year—a lot less than many of us spend on cigars.

Some doctors (about 4 per cent) go into research and teaching. They are notoriously underpaid. Well, if this plan works, medical schools will be in the black and they could pay their researchers and full-time professors as

generously, in proportion, as they now pay their master-carpenters and janitors. And when the research and teaching people got a living wage, they too could pay back their debts.

At first the Bird plan sounds unwise, because it puts a lien on the future. It is a kind of indentured servitude which is repugnant to the American mores. But on second thought, it doesn't sound so bad. Doctors often buy heavy equipment and mortgage their future earnings to pay for it. Take one of these new x-ray machines that stand up for a fluoroscopy, lie down for a flat plate, pivot and twist. The kind that turns the switch on and off, rings a bell when something goes wrong, imprints the name on the film, flashes a red light for an abnormal finding, and has a feed-back to a bookkeeping machine for record purposes. Many doctors buy such robots for \$12,000 or \$15,000 and pay the company from future earnings.

So why not do the same with medical education which, after all, is the most valuable asset the doctor will ever have?

Your editor can say "amen" to such a proposal with enthusiasm and safety. We got out of medical school more than a quarter of a century ago. So, let's try this Bird of a Plan. They can't hurt us.

*See next page.

EDWIN R. RISTINE, M.D.

Camden

The Physician's Responsibility to the Community*

Coordination of health "drives" and the construction of intermediate hospitals are among plans suggested by Dr. Ristine for meeting the ever-widening social obligations of the physician.

ONE of the truly outstanding activities of the past year has been the Public Health Forum developed by the Public Health Committee of the Camden County Medical Society. It was then carried to fruition by the cooperation of practically every other committee of that Society. This is the first time that such an extensive community project has been consummated in southern New Jersey. Measured by the attendance at the four sessions of the Forum, its success was notable. Its beneficial effects were much broader than such a statistical index would indicate. Not the least important achievement was the demonstration that the doctors of our community can work together, indefatigably and harmoniously to pool their efforts in a common cause. We, as physicians, learned much of benefit.

One wonders why we must carry out intensive drives to acquaint the public with what we are doing for the benefit of the community. Should not these facts be self-evident every day of the year? Should not each physician, through his contacts with the public, educate his patients every day and night of each year? Would not this obviate the necessity for intermittent 'revivals'?

NO, FOR the trend of medicine is changing.

The art of medicine is today supplanted by an ever-increasing mass of scientific knowledge. No longer is the physician simply an understanding friend, meting out empirical treatments for any and all diseases. He is now one of a group of highly trained individuals in a community, among whom a division of labor has become mandatory by the immensity of the knowledge that has developed about disease and its treatment. The passage of the 'old-time doctor' may be for better or worse, but it is true. The public demands the pooling and intelligent use of scientific information for its protection. No longer does the philosophy of the individual physician looking after the individual patient hold. Instead there has developed the modern concept of the medical profession looking after the needs of the community—group caring for group, rather than individual for individual. And this concept carries into the many fields which comprise the modern practice of medicine—research, preventive medicine, public health, medical legislation, medical education, hospital management, health economics and the financing of medical care, to mention only a few. These are some reasons that make it necessary for cooperative public relations to complement individual efforts.

*Presidential address, Camden County Medical Society, May 4, 1954.

WITH the diversification of the field of medicine into many specialized sub-divisions there is arising a new danger. We must take care that concentration upon a single important field does not blind us to its fractional importance in the over-all picture. This tendency toward specialization in the study of disease has led to the formation of many organizations which accumulate large sums of money earmarked for a single, well-demarcated cause. There are now many groups interested in ever-narrowing fields:—heart, cancer, cerebral palsy, poliomyelitis, tuberculosis, even nephrosis, to mention only a few. Workers, paid and volunteer, have become almost fanatical in their zeal to gain support for their individual causes. They have become competitive, rather than cooperative in a coordinated, soberly realistic campaign for public health. I urge doctors to take the initiative in creating a central control committee, to which all such groups would be accountable and thus create an expert, experienced, realistic and eminently fair over-all consciousness to evaluate the relative importance of each of these groups in the health of the community. Emotional appeal should not be the yardstick of importance. Today, it seems to be the only one available to the public.

INTERMEDIATE HOSPITALS

IN THE province of our expanding interest in community health another problem becomes apparent. With the marked rise in population now occurring in New Jersey, the adequacy of hospital facilities becomes an important matter in the care of the area's health. Health insurance plans, both individual and industrial, along with advances in treatment requiring specialized personnel and expensive centralized equipment, constantly increase the proportion of patients who are hospitalized. Hospitals are community institutions and must be constructed and subsidized by the individuals and industries of the community which they serve. How-

ever, hospitals are expensive buildings, housing expensive equipment and staffed by armies of personnel, including many highly paid trained technicians.

Many patients now occupying hospital beds do not really require the expensive facilities of the modern hospital. These patients are either convalescent, or are the victims of chronic diseases requiring, for the most part, minimal nursing care predominantly. Our area hospitals contain sufficient beds for the present needs of the community, if those beds are occupied only by patients requiring active hospital care. To relieve the hospitals of the load imposed by convalescence and chronic illness is an urgent need. This worthy goal could be achieved by the construction of convalescent centers to which could be sent the convalescent and chronically ill of all our hospitals. This would free beds for those patients who require the expensive specialized facilities of the active hospital. Convalescent centers can be constructed economically; they could be one-storey structures. This would obviate the necessity for stairs or elevators. They could be staffed by practical nurses with one or two supervising trained nurses. Motor court style architecture, with central dining room, avoiding costly room service of meals would be appropriate. Location should be suburban to avoid expensive land costs. Patients might help with the lighter tasks of care and maintenance both as a form of therapy and to reduce costs of patient care. Medical care should be in the hands of the family physician who could visit the patient here as he would in the home. These are the bare essentials of the type of community project which might help to answer the problems of inadequate hospital beds and the high cost of hospital construction and maintenance.

OTHER fields and problems command the attention of the medical profession as a group today. We must face our widening responsibilities. The individual physician is no less important than formerly—but the group importance is infinitely greater. Thus, may the future of medicine be as noble as its past!

Ocular Palsy As a Complication of Diabetes

Ocular muscle palsy is not only a rare complication of diabetes; it is rarely mentioned. Dr. Feldman cites a case of his own and reviews the literature.

OCULAR muscle palsy is one of the most annoying complications of diabetes. It may produce an incapacitating diplopia. It may also be innocuous, as shown by its termination in complete restoration of normal function. In a large series of diabetic eyes, Waite and Beetham,¹ found the incidence of paralysis of extrinsic ocular muscles to be 0.4 per cent. This frequency is less than one-tenth that of transitory refractive changes. In a much smaller series Leopold² found an incidence of 5 per cent. Gray³ found that the ratio was 0.4 per cent in his survey.

CASE REPORT

A 50-year old cafeteria counterman was referred to me because of blurring and double vision. This had been present for one week. He had a 'buzzing' in the left ear and a slight headache. Since 1942, he has known that he had diabetes mellitus. His insulin dosage had been 70 units, protamine zinc, daily since 1950. His diabetes had not been under strict supervision as he would consult a physician only when special difficulty arose. This was the first episode of any severe eye disability. He had been using correcting lenses, needing them principally for near vision.

His vision is 20/30, each eye, without correction. The significant finding was the paresis of the right lateral rectus. The right eye could be abducted only slightly past the midline. Upon measurement, there was an esotropia greater for distance than for near. Although he alternated he had a slight preference for the right eye.

Fundoscopy examination showed some fine dots of microaneurysms and hard exudates in the retina consistent with diabetes mellitus. There was no elevation or pallor of the discs. Slit-lamp examination did not disclose changes in the anterior segments or the lenses. Central field examination showed a small generalized contracture but this was his first examination and did not appear significant.

To enable the patient to get about, the left lens was occluded. This was consistent with the eye dominance. It also permitted further stimulation of the right eye, helping increase its lateral excursion.

When the patient was next seen, (three weeks later) he was taking 80 units of insulin daily. The increase in insulin was due to infected callouses. Movement of the right lateral rectus had slightly improved. The esotropia measured 20 prism dioptres for distance and 10 prism dioptres for near vision. He still had diplopia when he tried to make use of both eyes. Two months later, the paresis of the external rectus had disappeared. Findings were then normal both for distance and near.

The paresis-paralysis usually clears up in two to three months, although it may take as long as a year.

Waite and Beetham¹ state, "The sudden onset of the paralysis or paresis, and its slow disappearance, would suggest hemorrhage (nu-

1. Waite, J. H. and Beetham, W. P.: New England Journal Medicine, 212:367-379 and 429-443, 1935.

2. Leopold, I. H.: American Journal of the Medical Sciences, 209:91, 1945.

3. Gray, W. A.: British Journal of Ophthalmology, 17:577, 1933.

clear) as a possible cause. Such a hemorrhage would have to be minute to involve but one ocular muscle." Walsh⁴ says: "by some, such palsies are considered an indication of polyneuritis but it seems more probable they are occasioned by vascular lesions affecting the nerves." And, he adds: "rapid recovery, when and if it occurs, rather supports the polyneuritis idea. If hemorrhage in the brain stem is responsible, the physiologic block might be of short duration."

THE duration of the diabetes before the onset of the ocular muscle palsy is shown in the table below. It is usually less than three years. Twelve of the sixteen cases began before the third year.

The order of frequency of the cranial nerves, supplying the extraocular muscles involved are: (1) the sixth, (2) the fourth and (3) the third. Gray³ states that a sixth nerve lesion should make one think of diabetes after excluding para-syphilitic lesions.

Management consists in preventing the diplopia by occluding one eye and in watchful waiting.

In reviewing recent textbooks on diabetes mellitus, I find that complications of refractive errors, cataracts, retinal disease and Argyll Robertson pupils are listed, but not ocular muscle palsy.

IN MY collection, only one book—that by Joslin⁵ does consider paralysis of ocular muscles as one of the complications of diabetes. Unquestionably there are other diabetes texts which do the same, but I have not seen them. The complication is not only a rare one—it is also a rarely mentioned one.

TABLE. ADAPTED FROM WAITE AND BEETHAM¹

Duration of Diabetes at Time of Onset of Paresis-Paralysis	No. of Cases	Cumulative
Less than 1 year	3	3
1—1.9 year	4	7
2—2.9 years	5	12
3—4.9 years	1	13
5—9.9 years	3	16
	—	—
	16	

1060 Sanford Avenue

Hyperglobulinemic Purpura*

In 1943 Waldenström introduced the term hyperglobulinemic purpura to describe patients with an unexplained increase in serum globulin, an elevated sedimentation rate, and purpura of many years' duration. He noted that this condition was benign and that it had to be differentiated from multiple myeloma, which is similar in many respects.

Thus far thirteen patients with this disease have been reported in the literature. The characteristic findings are purpuric lesions which occur in periodic showers in the lower extremities. They are often brought on by unusual ex-

ertion, prolonged standing, or excessive pressure from clothing. After repeated episodes the skin shows a residual brown pigmentation. These purpuric attacks last from two to nineteen years with an average of ten.

In addition to the skin findings, laboratory tests show a high gamma globulin, a markedly increased sedimentation rate, a mild anemia and some impairment of renal function. After long periods of study no evidence of multiple myeloma is found. No specific treatment is described.

*Taylor, F. E. and Battle, J. D., Jr.: Benign Hyperglobulinemic Purpura: Case Report, *Ann. Int. Med.* 40:350, February 1954.

4. Walsh, Frank B.: *Clinical Neuro-Ophthalmology*, Williams and Wilkins Co., Baltimore, 1951.

5. Joslin, E. P.: *Treatment of Diabetes Mellitus*. Lea and Febiger, Philadelphia, 1937.

FRED B. ROGERS, M.D.*

Trenton

Thomas Dunn English--Doctor of Verse

This fascinating biography of one of New Jersey's most notable author-physicians suggests a re-appraisal of Dr. English's writings.

FROM early times physicians have identified themselves with activities outside their chosen vocation. In politics and statecraft, exploration and invention, art and literature, they have attained positions of leadership. Through literary efforts doctors often have captured the spirit of the times and in so doing projected their personalities upon an historic tapestry. Dr. Thomas Dunn English of New Jersey, a prominent public figure in nineteenth-century America, closely paralleled in his life and works the growth of a vigorous new nation. Like his better-known contemporaries, Oliver Wendell Holmes and S. Weir Mitchell, he practiced medicine but writing claimed much of his time. Versatile and energetic, Dr. English successfully followed several professions — literature, politics, law and medicine—achieving recognition of varying degree in each field. Although he is remembered today almost solely for his poem, "Ben Bolt," and his association with Edgar Allan Poe, English did a vast amount of literary work during a long and varied career. His verse is still connected with the state where he spent most of his days.

Descended from Quaker ancestors who were early settlers in New Jersey, Thomas Dunn English was born near Philadelphia on June 29, 1819. After a preliminary education at the Friend's Academy in Burlington, N. J., he received his M.D. degree from the University of Pennsylvania in 1839 at the age of twenty. His doctoral thesis had as its subject phren-

ology, the now-obsolete study of the mind and character from the shape of one's skull.

FOLLOWING a brief medical practice, Dr. English studied law and was admitted to the bar in Philadelphia in 1842. (He later recalled, "I never was lawyer enough to hurt me.") His energies during this interval were turned more toward writing for magazines than practicing his professions. At the time of his medical graduation he was contributing to *Burton's Gentleman's Magazine*, through which connection he met Edgar Allan Poe, one of the editors, of whom English became a close friend and later an adversary. In 1843, English achieved lasting fame with the publication of his ballad, "Ben Bolt," the popularity of which endures to this day. Only recently, Carl Carmer, the compiler of American folklore, chose this song as best typifying the spirit of the Delaware River.

Neither the medical nor legal calling seems to have suited Thomas Dunn English, for after considerable journalistic work in Philadelphia he moved to New York in 1844 to edit a daily paper. The same year found him entering politics as an advocate of the annexation of Texas. At that time he also figured prominently in the presidential campaign which resulted in the election of James K. Polk.

*Instructor in Medicine, Temple University School of Medicine, Philadelphia, Pa.

From 1842 to 1852 English accomplished a vast amount of literary work. During this period he wrote several novels and plays, many poems, editorials, scientific articles and political documents. Not forsaking medicine, however, in 1851 he edited and contributed several papers to a short-lived medical journal, *The Philadelphia Lancet*.

IN THE next year (1852) Dr. English returned to the active practice of both law and medicine, this time at Lawnsville, Virginia (now Logan, West Virginia). In addition he also served as first mayor of the town. Paying little attention to literary pursuits, the doctor rode rural circuit on horseback, carrying law books and surgical instruments in his saddle bags. It is said that he often argued law cases and performed operations on the same day during a five-year stay in Virginia. In 1855 he returned to political prominence by becoming a vigorous opponent of the "Know-Nothing" political movement of that time. Three years later he returned north—to New York—and in the following year (1858) moved to New Jersey, his home for the remaining forty-five years of his life. Practicing medicine at Fort Lee and Hackensack township during the Civil War, he also served as a member of the New Jersey Legislature from Bergen County. At that time (1863-64) he took an active part in the political contest which led to the disruption of the Democratic party and the election of Abraham Lincoln. Continuing public activity after moving to Newark in 1878, he was elected to represent the Essex district in Congress for two terms (1890, 1892). He was later defeated when he ran for a third term at the age of seventy-six.

A MAN of wide interests, at the sixteenth anniversary of his medical commencement from the University of Pennsylvania he addressed three different alumni groups—receiving a hearty ovation from each. A founder of the American Archeological and Numismatic Societies, he also served as vice-president of the Society of American Authors and was a mem-

ber of the American-Irish Historical Society. His manifold talents included skill at carpentry, geology, music and oratory. In recognition of his accomplishments, the College of William and Mary awarded him an honorary LL.D. degree on July 4, 1876. Married to Annie Maxwell Meade of Philadelphia in 1856, their union produced four children. Dr. English survived his wife but three years, becoming almost blind before his death at Newark on April 1, 1902.

As so often happens, the generations following an author's death tend to forget or undervalue him. This is especially true of persons whose reputations were overinflated by their contemporaries. Such a process has been particularly operative upon Thomas Dunn English. In spite of a vast literary output his poems are little read today, his novels and plays outmoded and his other writings not readily available. Being primarily concerned with contemporary events, his style was generally more charming than profound. No matter what else he was doing, English was writing—and writing hurriedly. Had he taken more care with the technic of his verse, its value would doubtless have been far greater. Through his lines, however, there appeared much that was representative of American life during the nineteenth century. In spite of admittedly writing for pay and catering to public tastes rather than aiming for literary distinction, this doctor of verse has left us some worthwhile poetry. His better works evidence a keen appreciation of our American heritage. Allied with this are a realistic touch and a sense of the picturesque—both important in creative writing. After a half-century of relative obscurity it is time for a re-evaluation of the man and his works.

ROMANTICISM, the dominant strain of the nineteenth century, with its emphasis on individualism, sentiment and natural description, appears throughout the writings of Thomas Dunn English. His nostalgic ballad, "Ben Bolt," typifies the romantic spirit of his era. This lyric, one of the most popular songs of the past century, was originally contributed to the *New York Mirror* at the request of its editor, Na-

thaniel Parker Willis. The latter had asked English to write a sea song for his publication. Seeking inspiration for the subject, the author could think only of his happy ancestral home, "The English Farm," in the Delaware Valley. Dedicating his hurriedly-composed ballad to an old friend, Charles Benjamin Bolt, its verses first appeared on September 2, 1843. A nautical flavor was evident only in the final line, with its reference to "Ben Bolt of the salt-sea gale":

Don't you remember sweet Alice, Ben Bolt,—
Sweet Alice whose hair was so brown,
Who wept with delight when you gave her a
smile,
And trembled with fear at your frown?
In the old churchyard in the valley, Ben Bolt,
In a corner obscure and alone,
They have fitted a slab of granite so gray,
And Alice lies under the stone.

There is a change in the things I loved, Ben Bolt,
They have changed from the old to the new;
But I feel in the deeps of my spirit the truth,
There never was change in you.
Twelvemonths twenty have passed, Ben Bolt,
Since first we were friends—yet I hail
Your presence a blessing, your friendship a truth,
Ben Bolt of the salt-sea gale.

DR. ENGLISH wrote to Willis on submitting this manuscript, "If you don't like this stuff, burn it, and I shall send you something when I am more in the vein." The editor, however, sensed its appeal and the poem was accepted—only the word, "blushed," in the third line was printed as "wept"—an error which remained in the song. Originally set to music by its author (to a tune composed "entirely for the black keys"), the song became widely popular when Nelson Kneass (the Pittsburgh minstrel who introduced many of Stephen Foster's songs) adapted it to an old German melody and sang it in a melodrama, *The Battle of Buena Vista* (1848). Newspapers throughout the United States, Britain and Canada copied "Ben Bolt" and it was widely recited, sung and quoted. Later, during the Civil War, it became a favorite of soldiers on both sides of the lines.

The Library of Congress still lists twenty-six different compositions to this song. Its au-

thor, however, who never received a penny for his work, came to resent its enormous popularity when compared with what he considered more important efforts. He was particularly annoyed by requests for autographs or locks of hair and the fact that its name was given to a clipper ship, a steamboat and a racehorse. According to English, who jokingly dubbed his song, "one of my early indiscretions"—"the ship was wrecked, the steamboat blew up, and the horse never won a race."

THE novelists also did well by "Ben Bolt"—better than with most popular songs. In a popular British novel (1877) this song became the means of effecting a reconciliation between two separated lovers. Later, in America, George W. Cable had the heroine sing it in his *Dr. Sevier* (1883). As a song of the hour it subsequently met renewed popularity when given prominence by the English novelist, George Du Maurier, in *Trilby* (1894). In this novel the Parisian girl, Trilby O'Ferrall, could only render "Alice Ben Bolt" when under the spell of the hypnotist Svengali.

By chance or merit "Ben Bolt" has remained English's lasting claim to literary fame. It is said that the attention paid to him in the House of Representatives was due as much to this authorship as to any other cause. He continued to speak slightly of it, however, in spite of its worldwide success. At a meeting of the Essex County Medical Society, of which Dr. English was an active member, a quartet appeared on one occasion to sing "Ben Bolt" in his honor. Obviously annoyed, the doctor threatened to leave the gathering if the song were not promptly discontinued—a wish quickly fulfilled.

EARLY attracted to journalism, Thomas Dunn English began writing for Philadelphia newspapers at the age of sixteen. It was thus that he met Edgar Allan Poe who helped edit *Burton's Gentleman's Magazine* and *Graham's Magazine* during his residence in Philadelphia. Because of personal arguments, however, their friendship was short-lived. In 1844, Dr. Eng-

lish later recalled, "I was president of a political club, and did a good deal of stumping. I dare say that I was unnecessarily offensive in my remarks at times and provoked a deal of ill-will."

In the same year he moved to New York where he held a political appointment as weigher for that port and edited a daily paper, the *Aurora*. About this time he also published a coarse but vigorous poem, "The Gallows-Goers," which was widely circulated in current agitation against capital punishment. In 1845 he tried his hand at editing the *Aristidian*, a literary magazine to which both Poe and Walt Whitman were contributors, but which failed after six issues.

The following year brought an open clash between English and Poe, climaxed by a fist-fight between them in the streets of New York. English knocked Poe down and mauled him severely. In retaliation Poe ridiculed his opponent in a scurrilous article in his series, "The Literati of New York," published in *Godey's Lady's Book*. English replied with even greater heat by a card, reprinted in the *New Mirror*, charging his rival with forgery. As a result of this charge Poe sued the paper for libel and was awarded \$225 for damages. During the trial English hastily changed his residence to Washington. It is said that the stir created by this suit did much to becloud Poe's reputation for the next half-century. Fifty years later (1896), in an article, "Reminiscences of Poe," English wrote an interesting sketch of Poe without evidencing rancor toward his former rival.

CONTINUING as a stormy petrel in political journalism, Dr. English edited a humorous periodical at Philadelphia in 1848 entitled *John Donkey*. This sheet attained wide circulation but its satire was often vicious, with attacks upon Horace Greeley, Poe and others. Libel suits ruined *John Donkey* after it had brayed valiantly for several months. In the same year English wrote a book on the 1848 French revolution in collaboration with G. G. Foster. Undaunted by earlier setbacks, English again became editor of a political paper, *The Old Guard*,

in 1870. Like his other journalistic ventures, however, it died on his hands after a short while. Later, when residing at Newark, he served for a time on the literary staff of the *Newark Sunday Call*. Constantly contributing prose and verse to periodicals, his newspaper articles alone would fill a score of volumes.

Exclusive of the immortal "Ben Bolt," Thomas Dunn English's reputation as a poet rests upon a collection of ballads, a group of stirring battle lyrics and some moving nature verses. His first book, a volume of poems published in New York in 1855, was suppressed for some obscure reason by its author. "I write poetry," he said toward the close of his life, "because publishers pay me well; publishers pay me well because the public seems to like my themes . . . and so long as I am paid, and no longer, I shall continue to write."

A PHENOMENALLY rapid writer, his long poem, "Kallimais," nearly six hundred lines, was written in a single day and published without revision. It is said that he produced three poems, "The Logan Grazer," "The Canoe Voyage," and "The Wyoming Hunter," about four hundred lines in all, between eight and eleven in one evening! Supporting his position that the country needed a more representative national anthem, English also wrote two hymns intended to replace "The Star Spangled Banner." Neither, however, proved popular. His daughter, Alice, later collected all his poems (covering a wide range of topics from legends to dialect studies), excepting the battle lyrics, in a volume, *The Select Poems of Dr. Thomas Dunn English* (1894), published by subscription. Three years later, another daughter, Florence English Noll, edited his *Fairy Stories and Wonder Tales*, and in 1904 his son-in-law, Arthur H. Noll, brought out a similar volume collected from periodicals.

Through his folk ballads (published in book form as *American Ballads* in 1879) Dr. English made his most significant contribution to our American heritage. Folklore, a knowledge of the creative workings of the mind of its folk, is the key to a nation's values—a highway that leads into the heart of its people. In addition

to "Ben Bolt," such verses as "Kate Vane," "Keep the Mill a-Going," and "The Ballad of Brave Bill Anthony," tell of duties and pleasures common to us all. These ballads exhale the captivating fragrance of an age which was far less complicated than our own. Again in such "urban verses" as "The Surgeon's Story," or "Smiting the Rock," the author betrays a deep human sympathy.

ORIGINALLY planning to write a complete metrical history of the United States, English found this task too formidable. In its place he published *The Boy's Book of Battle Lyrics* (1885). These sketches, first issued during the Civil War, told of incidents of courage and patriotism in American history—a stirring collection of verse. Who does not thrill, for example, to "The Charge by the Ford," lines describing a cavalry ambush:

Eighty and nine with their captain
Rode on the enemy's track,
Rode in the gray of the morning:
Nine of the ninety came back.

Up with three cheers and a tiger!
Let the flags wave as they come!
Give them the blare of the trumpet!
Give them the roll of the drum!

In his nature verses Thomas Dunn English has left us vivid descriptions of our country's natural beauty. His "rural idyls" reveal a fine appreciation for American landscapes. "The Mountain Stream," "Rafting on the Guyandotte," and "The Delaware" are among the best in this class. In the last poem one can sense the majesty of New Jersey's great river:

Down through the hills and through valleys that
glow
With the sun from above and the green from
below,
On by the cities that lie at my side,
Growing deeper and wider, I quietly glide
Past where the Schuylkill pays tribute to me,
Till I reach in my journey the fathomless sea.

There where the ships from the North and the
South,
And the East and the West, with their keels vex
my mouth,
I mingle my waters with those of the main,
Bury my flood in the flood of the ocean,
Whose motion repels me again and again,
Yet flowing and flowing.

ALMOST unknown today, the many plays and several novels by Dr. English bespeak his prolific writing—largely with an aim to entertain. His best known drama, "The Mormons, or Life in Salt Lake City" (1858), is said to have been written in three days. Of timely interest on the Mormon controversy, it was the only one of his more than twenty plays to be published. As a playwright English was notoriously facile. One play, written in forty-eight hours, featured journeymen-printers as the main characters. Another production he described as "a rhyming extravaganza, in which the actors were all to be gigantic frogs." Notwithstanding their subject matter, a number of his plays were produced in New York and Philadelphia theaters—with considerable success. These plays were said to have been marked by sprightly dialogue and diversity of character, but lacking in novelty or plot construction. Also forgotten today are his novels which include: "Walter Woolfe" (1842), "1844; or The Power of the S. F." (1845), "Ambrose Fecit; or The Peer and the Painter" (1869), and "Jacob Schuyler's Millions" (1885).

Remembered today chiefly for one engaging poem and through his contact with Edgar Allan Poe, Thomas Dunn English of New Jersey still offers in his verses much of value to the interested reader. A versatile physician who did many things well, he wrote voluminously on many subjects during his long life which encompassed a century of vigorous American growth. Like other doctors of verse his contributions to literature can well be summarized by a recent statement of the President of the Royal College of Physicians, Sir W. Russell Brain:

Doctors may justly feel proud of their profession's contributions to literature . . . The doctor occupies a seat in the front row of the stalls of the human drama, and is constantly watching, and even intervening in, the tragedies, comedies, and tragi-comedies which form the raw material of the literary art. If the doctor is to be capable of his work, he must be a man of feeling; and if he is to do his work, his feelings must often in great measure be denied expression. Perhaps this is partly the reason why doctors express themselves in writing; but it does not explain why they so often express themselves well, nor why so many authors, some among the most distinguished, have come to the writing;

of poetry, plays or novels by way of medicine. Whatever the explanation, we may all be grateful that so many doctors, whether they have achieved liter-

ary fame or not, have written clearly and gracefully, humorously and movingly about the fundamentals of life and of their profession.

Donnelly Memorial Hospitals

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Tonsillectomy and Bulbar Polio

A polio victim who has had his tonsils removed is about four times more likely to have the bulbar type of polio than a patient who still has tonsils. So Anderson and Rondeau reported in the July 24, 1954 issue of the J.A.M.A. This was based on a study of more than 2,000 victims of a 1946 polio outbreak in Minnesota.

W. Anderson and J. Rondeau, A.B., (University of Minnesota School of Public Health) said their study did *not* show that persons without tonsils are more likely to get polio. However, if "recognizable" polio does occur, the patient without tonsils is in more danger of having the bulbar type. Aside from the first month after operation, when bulbar incidence is lower than in later months, it makes no difference how long before the polio attack the tonsillectomy was performed, they said.

Bulbar involvement occurs in over a third of the patients whose tonsils are *not* present at the time of the polio attack. Less than a tenth of the patients who have not had tonsillectomy show the bulbar type.

The lack of cases of bulbar type polio in certain areas may be due to the concentration of polio in ages before tonsil removal. Egypt, Chile, and Japan have almost no bulbar polio, probably because of the almost complete ab-

sence of tonsillectomies at ages when polio is likely to strike.

The Minnesota study (aided by a grant from the National Foundation for Infantile Paralysis) showed that 71 per cent of the persons with bulbar polio had undergone tonsillectomies as contrasted with 28 per cent of the 936 with severe spinal polio; 32 per cent of the 908 with mild spinal, and 34 per cent of the 290 nonparalytic cases.

"Even more significant than the absolute difference between the bulbar and other groups is the fact that this difference holds at all ages and in both sexes," they said.

If "recognizable" polio developed in a child who still had tonsils, the chances were one out of 12 that the infection would be bulbar, but, if the child had at some time had his tonsils removed, the chances were more than one in three.

There were 273 more bulbar cases in the entire group than might have been expected if all had had the same rate of bulbar involvement as did the group of patients who had not had tonsillectomy.

It is probable that tonsillectomy removes some "natural barrier" which would have prevented the spread of polio virus from the throat to the brain stem.

Thyroid Disease in Persons with Emotional Disorders

Psychoneurotic symptoms may mask as thyroid disease. Hyperthyroid patients may be mislabelled "neurotic." The differential diagnosis is here spelled out.

THE diagnosis of frank hyperthyroidism or myxedema is simple when they are considered in a differential diagnosis. Milder forms of thyroid disturbance are more difficult to diagnose, particularly in neurotic and psychotic individuals. Such persons pose special diagnostic problems. The history may be quantitatively inadequate, or vividly detailed but unreliable. Furthermore, these patients may be unable to cooperate for the necessary physical and laboratory examinations.

In the past, a number of writers have pointed out that the presenting symptoms of thyroid disturbance may be atypical. There is an excellent review and discussion by Breidenbach and Applebaum¹ on "Masked Hyperthyroidism."

Previous knowledge of the patient's physical status and personality are very valuable in appraisal of changes.

Certainly the doctor should look for the usual classical symptoms and signs of thyroid disturbance; some of the more common ones are listed in the following tables.

"SUSPICIOUS" SYMPTOMS

Hyperthyroidism

1. Anxiety
2. Lassitude
3. Sweating
4. Preference for cold weather
5. Weight loss without anorexia

6. Hoarseness, dysphagia
7. Diarrhea, vomiting, abdominal pain
8. Angina, dyspnea, palpitation

Hypothyroidism

1. Lethargy
2. Dry skin
3. Preference for warm weather
4. Excess weight gain
5. Chronic constipation
6. Joint pains without other evidence of arthritis

"SUGGESTIVE" SIGNS

Hyperthyroidism

1. Warm, wet skin
2. Exophthalmos; lid lag; wide palpebral fissure; decreased winking
3. Hand tremor
4. Enlarged thyroid; systolic thrill; bruit
5. Sinus tachycardia; cardiac arrhythmia (especially persistent auricular ones not responding to digitalis therapy); evidence of cardiac failure; hypertension (primarily systolic)

Hypothyroidism

1. Cool, dry, indurated skin; puffy face and eyelids; coarse features; scanty eyebrows and scalp hair
2. Large tongue
3. Small thyroid
4. Bradycardia; hypotension

1. Breidenbach, L. and Applebaum, E.: Masked Hyperthyroidism, Ann. Surg. 115:184, February, 1942.

The following history indicates the type of confusion sometimes found.

1. A 36-year old female complained of chest pain, dyspnea, lethargy and depression for six years. She had been treated by various physicians for "neurosis," anemia, low blood pressure, falling hair, dry skin, etc., etc. Physical examination revealed a typical picture of myxedema. BMR studies varied between 37 and 54 per cent. Thyroid extract was administered starting with one-half grain daily and gradually increasing to one and one-half grains daily over a period of three months. After five months of treatment, lethargy and depression had disappeared as well as most of her other complaints.

CERTAIN laboratory tests are helpful in the estimation of thyroid function. The serum cholesterol and galactose determinations are useful. The finding of low hemoglobin, low gastric acidity, or low voltage QRS and T waves in the electrocardiogram may excite suspicion of hypothyroidism. Glycosuria may be present in hyperthyroidism.

The classical basal metabolic rate determination is more specific, but frequently not more precise than the foregoing tests.

If they are available, the blood protein bound iodine and radioiodine uptake tests should be used. They are precision tests.

There are four diagnostic procedures that are simple and helpful in studying thyroid function of disturbed patients.

1. Serial observation and recording of the patient's temperature.
2. Serial observation and recording of the sleeping pulse rate.
3. Standard basal metabolic studies with prior sedation.
4. Therapeutic trial.

The rectal temperature should be taken morning and evening for five days. If the readings are uniformly higher than normal by one or two degrees, hyperthyroidism may be present.

The sleeping pulse rate should be counted and recorded twice nightly for five days; a person with a sleeping pulse rate consistently below 100 is unlikely to have hyperthyroidism. If the sleeping pulse rate is consistently above 72, hypothyroidism is unlikely.

THE basal metabolic rate may be determined with prior sedation. That is, the patient may be given Sodium Amytal® Gm. 0.2 orally one hour before a standard test. In hyperthyroidism, the pre-medication has no diminishing effect on the test result; in a psychotic patient who is euthyroid, the result of the test will be normal.

The two cases described below point out the usefulness of this simple procedure.

2. A 75-year old widow with a severe anxiety syndrome, had lost 12 pounds in three months. She had tremor of the hands and hypertension (present one year). She could not cooperate for basal metabolism studies at first, but was able to do so after taking Sodium Amytal® 0.2 Gm. orally. The curves were consistent. Basal metabolic rate was plus 27 per cent.

3. A 62-year old woman with considerable marital difficulty had lost 13 pounds recently. She complained of insomnia and depression. She had essential hypertension. Symptoms were unrelieved after large doses of estrogen. She could not cooperate for metabolic or temperature studies. After receiving 0.25 Gm. Sodium Amytal® intravenously, several metabolic tests were done. They ranged from plus 25 to plus 50 per cent. She received propylthiouracil 50 mg. four times a day (by mouth) for twelve months without toxicity and with considerable benefit. She relapsed one month after medication was discontinued. A radioisotope uptake test was then done and the value was 86.5 per cent in 24 hours. She received radioiodine therapy and improved considerably. Remission has lasted over two years.

A test of therapy with propylthiouracil 75 mg. orally four times daily for two weeks will confirm the diagnosis by diminution of symptoms and signs if hyperthyroidism is present.

The next two case histories reflect the value of this kind of therapeutic trial.

4. A 23-year old male schizophrenic was referred for thyroid evaluation. He had a history of rheumatic inactive heart disease, duration undetermined. Physical examination confirmed the diagnosis of rheumatic heart disease. He had a persistently rapid heart rate (ECG revealed sinus tachycardia) though he did not appear excited. He was unable to cooperate for temperature or basal metabolic studies. A therapeutic test with propylthiouracil was of no benefit. He was considered euthyroid.

5. A 29-year old male schizophrenic was referred for thyroid evaluation. He had had rheumatic fever

two years previously. He was a very excited patient with a marked tremor of the hands and a rapid heart rate. Blood cholesterol was 147 mgm. per cent. Serial ECG's revealed paroxysmal atrial tachycardia. He could not cooperate for temperature, pulse or metabolic studies. An extended therapeutic trial with propylthiouracil was of no benefit. He was considered euthyroid.

WHEN the above temperature, pulse and basal metabolic rate procedures are utilized together, a good clinical estimate may be made of the possibility of thyroid disturbance. The ther-

apeutic test may be utilized to confirm a clinical diagnosis of hyperthyroidism.

SUMMARY

1. A brief resume of the problems encountered in diagnosis of thyroid disease in neurotic and psychotic patients has been presented.
2. The usual symptoms, signs, and laboratory procedures have been summarized.
3. Four simple procedures are suggested for appraising function in psychotic patients.

139 South Street

Heparin in Angina Pectoris

In a controlled study on the effect of intravenous heparin in patients with a clear cut picture of angina pectoris, Chandler and Mann* found no subjective or objective evidence of improvement. Thirteen patients with angina of two months' to six years' duration were the subjects. All showed typical symptoms and all had abnormal electrocardiograms. The Master two-step test was done repeatedly in nine patients during the course of the study. Seven subjects showed typical changes after exercise. One subject had pain without electrocardiographic changes and the other showed neither electrocardiographic changes nor pain.

The method of control was the intravenous administration of 5 per cent glucose in water as a placebo. At varying times thereafter 100 mg. of heparin dissolved in 10 cubic centimeters of water was substituted for the placebo.

Eleven of the thirteen subjects showed moderate to marked relief after intravenous injection twice weekly of the placebo solution alone. The substitution of 100 mg. of heparin produced no advantage over the use of the placebo in alleviating the chest pain.

No hemorrhagic disturbances or other untoward effects were observed during the treatment with heparin.

* Chandler, H. L. and Mann, G. V.: Heparin Treatment of Patients with Angina Pectoris. New Eng. J. Med., December 24, 1953.

Boric Acid Poisoning

One hundred and five cases of boric acid poisoning have been reported in the literature to date. Goldbloom and Goldbloom* have recently added four additional ones.

The four patients currently described illustrate the danger of boric acid poisoning in infants following the application of such preparations to skin eruptions. The usual story is that of a young infant who develops diarrhea with secondary inflammation of the buttocks and for whom a boric acid powder or ointment is prescribed. The boric acid is absorbed, producing not only an increase in the excoriation but an aggravation of the diarrhea and vomiting.

The diagnosis of acute boric acid poisoning is not difficult. The erythema is usually intense and may involve the entire body. The palms and soles are often particularly affected and conjunctivitis may be present.

In infancy central nervous system signs may resemble meningitis. The turmeric paper test is a rapid method for detecting boric acid in the urine or spinal fluid.

There is no specific treatment for this type of poisoning. General supportive measures should consist of treatment of shock with plasma or whole blood and the maintenance of a good urinary output with intravenous solutions.

* Goldbloom, R. B. and Goldbloom, A.: Boric Acid Poisoning. J. Pediat., Dec., 1953.

NICHOLAS A. ANTONIUS, M.D.

DANIEL F. DOWNING, M.D.

HARROLD A. MURRAY, M.D.

PATRICK A. IZZO, M.D.

Newark

Pulmonary Stenosis*

Pulmonary stenosis is often complicated by atrial-septal communication, or a patent ductus, or the tetralogy of Fallot. Illustrative cases in all categories are cited.

PULMONARY stenosis is a relatively common congenital cardiac anomaly. It may be associated with a septal communication or a patent ductus arteriosus; with transposition of the great vessels, biventricular origin of the aorta (tetralogy of Fallot) or other serious defects. It may exist as an isolated lesion. The stenosis may be in the outflow tract of the right ventricle, the pulmonary valve or the pulmonary artery itself. Whatever the anatomic situation the physiologic result is the same: interference with blood flow to the lungs. Upon the associated anomalies depend the differences in some of the signs and symptoms of the various conditions. The diagnosis of the lesion is of more than academic interest, for it is remediable by surgery. We shall here consider four of the entities mentioned above, outlining the major features of each.

PURE PULMONARY STENOSIS

THE term "pure pulmonary stenosis" should be reserved for cases in which the cardiac septa are intact and there are no shunts or other abnormalities. The condition has been thought to be rare, but we have studied a number of cases and it is probable that we have

missed as many more. The stenosis is valvular in most patients, *i.e.*, the cusps of the pulmonary valve are fused and the right ventricle is normally developed. Cusp fusion results in a conical valve at the apex of which is an orifice of varying size. In rare cases the obstruction to pulmonary flow is due to arrest of the developmental process which terminates in incorporation of the bulbus cordis in the right ventricle. This is called infundibular stenosis, the persistent muscular tissue forming a perforated partition between the main cavity of the right ventricle and the pulmonary valve; the intervening space forms a chamber of varying size depending upon the level of the abnormal septum. Even more uncommonly there is generalized narrowing of the distal portion of the outflow tract.

It is obvious that the sole circulatory effect of this type of malformation is interference with right ventricular outflow. As a result of this, and in order to maintain cardiac output, the chamber must accept a greater burden than normal; by hypertrophy it is enabled to do so. Evidence of this right ventricular enlargement is found on fluoroscopy, for the retrosternal space may be encroached upon when viewed in the right anterior oblique position and the apex of the heart is elevated. The electrocardiogram, too, shows signs characteristic of right ventricular hypertrophy.

*From the Departments of Cardiology and Pediatrics, St. Michael's Hospital, Newark, New Jersey.

AS LONG as the chamber can compensate cardiac output is normal or near normal. The intact septa prevent a right-to-left shunt and all the blood going to the lungs is fully oxygenated. For these reasons, cyanosis, dyspnea and diminished cardiac tolerance are not features. However, when the right ventricle has passed the peak of its power to compensate, cardiac output falls. Only then do dyspnea and impairment of activity appear. With cardiac failure, peripheral blood stasis may lead to the development of cyanosis. The time of onset of these symptoms depends upon the degree of stenosis and the presence of secondary precipitating factors. Obviously, if the stenosis is extreme, cardiac failure and death will probably occur in early infancy. If of minor degree, a long life is possible.

The physical signs relating to the heart are not striking and have often been attributed to an interventricular septal defect. Increase in the area of cardiac dullness becomes apparent with rather marked enlargement of the right ventricle. If the stenosis is of such degree that the enlargement occurs in early life there will be prominence of the left chest anteriorly due to pressure on the easily moulded ribs of the infant. A thrill is palpable more frequently than not and is most intense somewhere in the area of the second, third and fourth left interspace, usually in the second and third. It is in this region, close to the sternal border, that a harsh systolic murmur is best heard. Apparently, the degree of stenosis bears no constant relationship to the loudness of the murmur. Transmission is variable; the abnormal sound may be localized or diffuse and is often easily heard posteriorly. The pulmonic second sound is diminished in intensity or absent, although in some cases it may appear to be normal.

IN ADDITION to evidence of right ventricular enlargement, x-rays show two important findings: the peripheral pulmonary vessels are diminutive and in many cases there is a prominent pulmonary artery. On fluoroscopy the appearance of this vessel differs from that in other congenital anomalies in which it is dilated (auricular septal defect, ventricular sep-

tal defect, aortic septal defect, patent ductus arteriosus) in that its pulsations are not forceful. The post-stenotic dilatation has been the subject of a number of explanations, none of which is entirely satisfactory. We have seen at operation in a number of patients with valvular pulmonary stenosis and a large pulmonary artery, a localized systolic bulge where a jet of blood entering through the narrow valvular orifice in an eccentric fashion hits the wall of the vessel. The younger the subject the more prominent has been the bulge and the smaller the artery. It appears possible that this localized trauma causes progressive stretching of the wall at the point of impact and eventually the entire vessel is affected. In those cases in which the jet enters in the axis of the vessel there is no dilatation. This theory may also account for the dilatation of the aorta so often seen distal to an area of coarctation.

Cardiac catheterization is of paramount aid in diagnosis. The interference with right ventricular outflow leads to an increase in intraventricular pressure. On the other hand, the pressure in the pulmonary artery, which should be in the same order as that of the right ventricle, is decreased. If a continuous pressure recording is made as the catheter is withdrawn from the artery into the ventricle there will be a sharp rise as the tip passes through the valve.

Relative stasis of blood in the dilated pulmonary artery results in an angiocardigraphic observation of some importance. The dye is pooled beyond the valve and opacification persists for an appreciable interval after it would normally have disappeared. This procedure is also of value in that it demonstrates impeded egress of the dye from the right ventricle. An illustrative case follows:

D.S. Age 7. Male. Cardiac murmur found at 5 months. No symptoms until age 5. Easy fatigue and shortness of breath on exertion progressive from that time. No cyanosis. Slight asymmetry of the bony thorax. No thrill. No cardiac enlargement. Second sound at left base inaudible. Moderately loud, harsh systolic murmur in 2nd and 3rd left interspaces. Electrocardiogram—right ventricular hypertrophy. Films and fluoroscopy—peripheral pulmonary vessels diminutive, pulmonary artery dilated. Right ventricle prominent. Cardiac catheterization data in Table. Pulmonary valvulotomy performed. Normal exercise tolerance following convalescence.

This patient had all the criteria for the diagnosis of pure pulmonary stenosis. Cardiac catheterization demonstrated an abrupt gradient in pressure between pulmonary artery and right ventricle and there was no evidence of a shunt. Valvulotomy, by increasing pulmonary blood flow, resulted in alleviation of his symptoms.

PULMONARY STENOSIS WITH ATRIAL SEPTAL COMMUNICATION

THIS lesion has been improperly referred to as "pure" pulmonary stenosis and has often been misdiagnosed as the tetralogy of Fallot. It differs from true pure pulmonary stenosis in that there exists the opportunity for a flow of blood from right to left with resulting reduction in arterial oxygen saturation; it differs from the tetralogy of Fallot in that the ventricular septum is intact.

If the foramen ovale does not become wholly sealed or if there is a defect in the interatrial septum, in the presence of pulmonary stenosis there may be sufficient increase in right heart pressure to allow a flow of blood from right to left auricle. This implies a certain degree of tricuspid insufficiency, developing as a result of dilatation of the right ventricle, or of inability of the right ventricle to accept the entire right atrial output. Because of the shunt there is admixture of oxygenated and unoxygenated blood in the left heart and, hence, in the arterial circuit. If there is enough unoxygenated blood to account for at least five grains per cent of reduced hemoglobin, cyanosis will be apparent. Cyanosis, then, is the main clinical finding which differentiates pulmonary stenosis with and without a septal communication. Because of the escape of unoxygenated blood from the right heart into the arterial circulation and its loss to the lesser circulation, less blood is being oxygenated. In addition to cyanosis, dyspnea and decreased exercise tolerance are important symptoms of the condition.

So far as examination of the heart is concerned, there is no characteristic finding which enables the examiner to differentiate this malformation from pure pulmonary stenosis un-

less the murmur of the septal defect can be heard as distinct from that of the pulmonary stenosis. This can sometimes be done. Fluoroscopy demonstrates the same feature in one as in the other. The degree of right heart enlargement is not as great in pulmonic stenosis with septal defect because of the pressure relieving mechanism, but this is of no aid in the individual case. Inasmuch as the stenosis is usually valvular, the pulmonary artery may be dilated.

CARDIAC catheterization is of diagnostic aid, if, in a patient in whom other findings are consistent, the catheter passes through the atrial communication into the left heart.

Angiocardiography demonstrates the same features as pure pulmonary stenosis and in addition there frequently is simultaneous opacification of both atria. If film exposures are not made at short enough intervals, the opaque medium may completely pass through the left heart chambers and be visualized in the aorta and right ventricle simultaneously, giving the impression of over-riding of the aorta.

M.M. Age 11. Female. Murmur discovered at 19 months. Recently, exertional dyspnea. On physical examination, slight cyanosis of nail beds. Heart questionably enlarged to percussion. Systolic thrill in second and third left interspaces. Loud, harsh systolic murmur in third left interspace. Electrocardiogram suggests right ventricular hypertrophy. *Films and fluoroscopy:* peripheral pulmonary vessels small, pulmonary artery dilated, right ventricle hypertrophied. Cardiac catheterization results in Table. Pulmonary valvulotomy performed. Normal exercise tolerance following convalescence.

The catheter tip passed from right atrium to left demonstrating the communication. In addition, there was a systolic pressure gradient between pulmonary artery and right ventricle and a significant difference between right ventricular and systemic pressures. Pulmonary valvulotomy relieved the burden on the right ventricle and the patient's symptoms disappeared.

PULMONARY STENOSIS WITH PATENT DUCTUS ARTERIOSUS

THIS combination of lesions is perhaps uncommon but not rare. We believe that a num-

ber of patients who have had a patent ductus ligated or divided have had a coexisting pulmonary stenosis which was not diagnosed. In some cases, following operation, the suspicion of the presence of a second cardiac anomaly has been aroused by the persistence of a systolic murmur and evidence of progressive right heart enlargement, with subsequent catheterization evidence of pulmonary stenosis.

The effect of the two lesions on the circulatory apparatus is readily apparent. The pulmonary stenosis, by interfering with right ventricular outflow, places a strain on that chamber. The patent ductus, by necessitating continuous recirculation through the pulmonary bed of a portion of left ventricular output, places a strain on the left heart. It has been stated that in the presence of pulmonary stenosis a patent ductus is compensatory. Unless there also exists a ventricular septal defect this is not true. In the condition under consideration there is no right-to-left shunt and the only effect of the ductus is to send fully oxygenated blood back to the lungs. This pulmonary recirculation results in a loss of oxygen to the tissues and increased work for the left ventricle. Rather than being compensatory the ductus is productive of additional harm. For this reason one should not hesitate to ligate or divide a ductus if coexisting pulmonary stenosis is known or suspected. Ideally, the two conditions should be corrected at the same operation.

This combination must be strongly considered in patients who have the systolic-diastolic murmurs characteristic of a patent ductus and, in addition, have a systolic murmur of different character a little lower along the sternum. In others, the ductus murmurs will overshadow that of pulmonic stenosis and only by catheterization or at operation, if the pulmonary artery be carefully examined following interruption of the ductus lumen, will the stenotic element be appreciated.

FLUOROSCOPY is of some help in diagnosis. Because of the pulmonary stenosis there will be right ventricular enlargement. The pulmonary artery will be prominent due to the contribution of blood through the ductus and, in

many cases, to the post-stenotic dilatation. Unlike other types of pulmonary stenosis the peripheral pulmonary vessels will not be diminutive. The ductus will also contribute evidence in the form of left ventricular enlargement.

Cardiac catheterization gives evidence of increase in right ventricular pressure. If the pulmonary artery is entered the pressure will be found to be lower than that of the ventricle if the stenosis is extreme. Otherwise, the ductus may contribute to increasing pulmonary artery pressure to a degree approaching that of the right ventricle. If a blood sample is taken from the artery and one from the right ventricle it will be found that the oxygen content of that from the vessel is greater than that from the chamber.

Angiocardiography will demonstrate slow emptying of the right ventricle. If a good levoangiogram is secured, the infundibulum of the ductus will be visualized and there will be reopacification of the pulmonary artery. Only rarely is the ductus itself visualized. Thoracic aortography will better demonstrate the same findings as the levoangiogram but will give no information in regard to the pulmonary stenosis.

M.P. Female. Age 5. Physical growth and mental development retarded. Dyspnea and fatigue on moderate exertion. No cyanosis. Heart somewhat enlarged to left. Systolic thrill in 2nd and 3rd left interspaces near sternal border. Long systolic and long diastolic murmurs in second interspace. In 3rd left interspace a systolic murmur of lower pitch. Electrocardiogram normal. Films and fluoroscopy—pulmonary vascular markings somewhat increased, main pulmonary artery prominent, right and left ventricles enlarged. Angiocardiography—questionable infundibular stenosis, prominent pulmonary artery, infundibulum of ductus and reopacification of pulmonary artery. At operation, ductus divided. Infundibular obstruction demonstrated with sound. Because this was not severe and patient's condition was poor, no attempt made to remove a portion. Postoperative course uneventful. Some improvement in physical status.

The decision to postpone relief of the pulmonary stenosis was probably a wise one because of the child's poor condition. Had the stenosis been severe, however, the proper course would have been to partially resect the obstructing tissue. Whenever possible, both lesions should be attacked at the same operation.

THIS is the most frequently encountered type of pulmonary stenosis. Associated with that anomaly are biventricular origin of the aorta and an interventricular septal defect. The site of stenosis may be at the valve, in the outflow tract of the right ventricle or in the artery; or there may be a combination of stenoses. It is generally believed that the usual site is in the outflow tract of the right ventricle (infundibular stenosis). In our experience, however, valvular stenosis has been quite common.

In addition to interference with pulmonary flow there is a right-to-left shunt. Part of right ventricular output enters the aorta and there is a resulting mixture of oxygenated and unoxygenated blood. This produces cyanosis. Inasmuch as only a portion of right heart blood goes to the lungs for oxygenation there is chronic oxygen want. Dyspnea and exercise intolerance result.

On physical examination there is cyanosis and clubbing of the digits. It should be mentioned that lack of cyanosis does not rule out the presence of the tetralogy because such cases have been seen. A systolic murmur, best heard in the third, or second and third, left interspace near the sternal border, is the rule. It is not entirely clear whether the murmur is due to the stenosis alone or to the combination of stenosis and interventricular septal defect. A thrill may or may not be felt. Of frequent occurrence in these patients is thoracic scoliosis; the explanation for its development is not presently known.

X-RAY and fluoroscopy in the classical case show abnormally clear lung fields due to diminutive peripheral pulmonary vessels. The heart is of normal size, but in the right anterior oblique position the right ventricle is seen to encroach upon the retrosternal space. The supracardiac great vessel shadow is narrowed, due to dextroposition of the aorta and the small pulmonary artery. The pulmonary artery segment of the left cardiac border is less prominent than normal, so that there is a

TABLE
CARDIAC CATHETERIZATION DATA

	Oxygen Content (vol%)				Pressure (in mm. Hg.)											
	SVC	IVC	RAh	RAm	RA1	LA	RV1	RVm	RVoft	PA	SA	RA	LA	RV	PA	SA
M. M.				11.9		14.9	13.0		13.0	12.5	16.2(88%) *	(3) +	(3)	67/0	18/8	145/85
D. S.	10.7	13.1	11.1	11.0	10.5		10.8	10.0	11.3		15.7(90%)	(4)		132/0	28/4	90/30
M. F. (a)	13.2		12.7		13.0			13.4			15.5(79%)	(3)		110/0	11/0	
(b)	12.4	13.5	12.3		12.4		12.6	12.8	12.7		16.7(94%)	(5)		100/0	16/0	125/75
SVC—superior vena cava.																
IVC—inferior vena cava.																
RA—right atrium.																
RV—right ventricle.																
h—high. m—mild. 1—low. oft. outflow tract.																
SA—systemic artery.																
LA—left atrium.																
PA—pulmonary artery.																
+—figures in parentheses refer to mean pressure																
*—oxygen saturation																
b—post-operative																
a—pre-operative																

concavity rather than a convexity in this region. Due to right ventricular hypertrophy the apex of the heart is elevated. The esophogram frequently demonstrates a right aortic arch. It must be stressed that this classical appearance is not always seen. Some of our cases of the tetralogy have had rather prominent peripheral pulmonary vessels. In a number, the pulmonary artery segment was budging, due to post-stenotic dilatation of the vessel.

Angiocardiography is of value in diagnosis. It demonstrates simultaneous opacification of the aorta and right ventricle and suggestive evidence of pulmonary stenosis. Cardiac catheterization is diagnostic if the catheter tip can be guided into the ascending aorta and if pressure studies indicate the presence of pulmonary stenosis.

M.F. Age 14. Female. Cyanotic from birth. From age 6 marked exercise intolerance and dyspnea on exertion. Frequent episodes of syncope. On physical examination cyanosis of lips and nail beds. Digits clubbed. Bony thorax asymmetrical. No cardiac enlargement and no thrill. Sounds obscured by long, harsh systolic murmur in 2nd, 3rd left interspaces. Electrocardiogram suggests right ventricular hypertrophy. *Films and fluoroscopy*: peripheral pulmonary vessels diminutive, main pulmonary artery

normal. Slight cardiac enlargement to left with elevation of apex, right ventricle prominent. Angiocardiogram—simultaneous opacification of right ventricle and aorta. Cardiac catheterization of right ventricle and aorta. Cardiac catheterization data in Table. Pulmonary valvulotomy. Normal exercise tolerance and loss of cyanosis postoperatively.

This patient had the tetralogy with pulmonary valvular stenosis. There was no left-to-right shunt at the ventricular level demonstrated by catheterization. Postoperatively, there was no change in right ventricular pressure. This has been a constant finding following the Brock procedure. However, pulmonary flow has been increased, as witnessed by the increase in arterial oxygen saturation, and there is still no evidence of a left-to-right shunt at the ventricular level.

SUMMARY

FOUR conditions in which pulmonary stenosis is an important feature have been reviewed: pure pulmonary stenosis, pulmonary stenosis with atrial septal communication, pulmonary stenosis with a patent ductus and pulmonary stenosis in the tetralogy of Fallot. Illustrative cases are cited.

306 High Street

Treatment of Measles Encephalitis*

Forty-one patients with measles encephalitis and encephalomyelitis were studied in a controlled investigation to evaluate the therapeutic efficacy of gamma globulin.

Patients given 20 cc. or more (0.43 cc. or more per pound of body weight) showed better results than those receiving a smaller dose of gamma globulin and those who received none. The first group had greater apparent complete recovery rate, reduced incidence and severity of sequelae, and fourteen of fifteen patients had a normal temperature by the third day. They also had a shorter period of hospitalization; there were no fatalities and no secondary complicating pneumonia. In spite of evidence of extensive nervous system involvement the patients made remarkable recoveries. Four patients who received gamma globulin

alone without antibiotics or sulfonamides recovered as rapidly as those given the latter two drugs. There were no local or systemic reactions to the gamma globulin.

The recommended dose is a total of 1 cubic centimeter per pound of body weight given intramuscularly in divided doses over a thirty-six to forty-eight hour period as soon as the signs and symptoms of central nervous system disease are present.

In addition to gamma globulin, other treatments such as adequate fluid and electrolyte intake, oxygen, antipyretics, suction, good nutrition, and sedatives as needed, plus antibiotics and sulfonamides are indicated.

* Odessky, L., et al.: Gamma Globulin in Treatment of Measles Encephalitis. *J. Pediat.*, November 1953.

Trustees' Meetings

May 19, 1954

(Minutes Approved June 6, 1954)

The reorganization meeting of the Board of Trustees was held on May 19, 1954, at Haddon Hall, Atlantic City. Following is a summary of the principal actions taken at this meeting:

Dr. C. Byron Blaisdell was unanimously elected chairman of the Board of Trustees for 1954-55.

Dr. Reuben L. Sharp was unanimously elected secretary of the Board for 1954-55.

In consequence of his election as second vice-president, Dr. Albert B. Kump submitted his resignation as a trustee. By unanimous action, the Board named Dr. Carl N. Ware, of Shiloh, to fill the unexpired term of Dr. Kump as trustee from the fifth district.

The recommendation of the Nominating Committee that The Medical Society of New Jersey name delegates and alternates to the medical societies of Pennsylvania and Delaware was approved by the Board. A motion was adopted naming the following delegates and alternates to serve when invitations are formally received: To the Medical Society of Delaware; delegate — Dr. John S. Madara, Salem; alternate—Dr. C. Spencer Davison, Salem. To The Medical Society of the State of Pennsylvania; delegate—Dr. Henry B. Decker, Camden; alternate—Dr. Reuben L. Sharp, Camden.

The Board adopted a motion to extend a vote of thanks to Dr. Jerome G. Kaufman for his untiring and successful efforts in conjunction with the conduct of the 188th Annual Meeting.

The Board also approved a letter of appreciation to the management of Haddon Hall for the fine service rendered during the convention.

June 6, 1954

A regular meeting of the Board of Trustees was held on Sunday, June 6, 1954, at the Executive Offices, Trenton. Following is a summary of the principal actions taken at this meeting:

Consideration was given to several items of business which had been referred to the House

of Delegates but had not been acted upon by that body. (A) The Board approved and adopted the recommendations of the Subcommittee on Medical Practice to establish the following criteria for medical consultants:

(1) Board certification in the specialty involved; or

(2) Fellowship in an approved "college," such as the American College of Surgeons, American College of Physicians, and so forth; or

(3) Rank of attending, associate, or consultant in the appropriate specialty in an approved hospital. Approved hospitals are those registered by the A.M.A., or approved by the American College of Surgeons, or which hold membership in the American Hospital Association; or

(4) Completion of an approved residency training and eligibility for board examination in the specialty involved in the consultation.

(5) Establishment of a committee in each component county medical society to pass on specialist qualifications of those within the county who do not qualify under any of the above categories, recognition by the county committee to be approved by the Board of Trustees of The Medical Society of New Jersey.

Consideration of the means of implementation was postponed until the next meeting.

(B) The Board approved and adopted the following recommendations made by the Annual Meeting Committee:

(1) That hereafter the general afternoon sessions be on medicine, surgery, obstetrics and gynecology, and that pediatrics be included only in the morning section meetings.

(2) That scientific booth space be laid out in backwall lengths of 8, 10, and 12 feet; that the floor plan be drawn up in advance accordingly; and that prospective exhibitors be offered space in these measurements, rather than that the floor plan be laid out in accordance with the space requested by exhibitors.

(3) Approval of report as a whole, including the suggestions that an item be carried in the *Newsletter* or *JOURNAL* requesting that members who want to present papers at section meetings should communicate with the appropriate section officers during the summer or early fall.

The House of Delegates had recommended that a pension-trust plan be adopted for the

employees of the Society, and that the Board appoint a committee to study several plans and to report to the House of Delegates at its next meeting. In compliance with this, the Board established a committee composed of the following members: Dr. C. Byron Blaisdell, Chairman of the Board of Trustees; Dr. Elton W. Lance, President; Dr. Marcus H. Greifinger, Secretary; Dr. Jesse McCall, Treasurer; and Dr. David B. Allman, Chairman of the Finance and Budget Committee.

In furtherance of the action of the House of Delegates approving the proration of available surgical benefits, the Board of Trustees instructed Dr. Costello, as senior A.M.A. delegate, to draw up a resolution embodying the recommendations approved by the House of Delegates of The Medical Society of New Jersey, for presentation to the House of Dele-

gates of the American Medical Association, after such resolution has first been approved by the officers of the State Society.

The Board approved the recommendation of President Lance, made in consequence of a request submitted by twenty members of the Eye, Ear, Nose and Throat Section of The Medical Society of New Jersey, that a separate Section on Ophthalmology be established.

Report was made to the Trustees that the term of Dr. Elmer P. Weigel on the State Board of Medical Examiners expires on June 26, 1954. The Board unanimously adopted a motion that Dr. Weigel's name be sent to the Governor in nomination for reappointment, together with two other names to be supplied by the chairman, Dr. Lloyd A. Hamilton and Dr. Carl N. Ware were subsequently designated as the other two nominees.

Vital Statistics by Counties Released

Births continue—by a large margin—to exceed deaths in New Jersey. In 1953, there were 113 thousand births and 53 thousand deaths. Based on figures issued by the State Department of Health, the vital statistics scoreboard for counties was:

County	Birth Rate	Marriage Rate	Death Rate
Atlantic	19.6	8.8	14.1
Bergen	24.5	7.1	9.3
Burlington	22.8	6.3	9.2
Cape May	20.1	9.4	16.1
Cumberland	23.9	7.6	11.5
Camden	23.9	8.5	10.5
Essex	20.4	8.9	10.8
Gloucester	25.1	7.1	10.4
Hudson	19.8	9.2	10.8
Hunterdon	20.3	7.3	11.8
Mercer	21.7	8.3	10.6
Middlesex	27.5	7.6	9.7
Monmouth	24.5	8.0	11.7
Morris	24.0	7.4	10.0
Ocean	24.7	9.1	13.8
Passaic	21.4	7.9	10.8
Salem	23.4	6.5	9.5
Somerset	23.4	6.9	8.6
Sussex	23.5	7.8	11.5
Union	22.3	7.2	9.4
Warren	21.8	7.4	12.3
STATE			
OF N. J.	22.5	8.2	10.5

All rates are in events per thousand persons. With respect to *births*, Middlesex should be the mecca for obstetricians and pediatricians. The birth rate on the banks of the Raritan is $27\frac{1}{2}$ per thousand persons, appreciably above the state-wide figure of $22\frac{1}{2}$. Middlesex's rate is extraordinary, in that there isn't another county in New Jersey with a rate in excess of 25.1. Gloucester gets the second prize in the stork derby. At the other end of the scale, the world's playground county (Atlantic) has the bottom birth rate of New Jersey with a figure of only 19.6 births per thousand. (Too many transients in Atlantic?). At that, Atlantic is nudged by Hudson, where the birth rate is only 19.8.

As for *deaths* the state average was $10\frac{1}{2}$. The high score was in Cape May with 16.1 deaths per thousand persons and the best was Somerset with 8.6. It is necessary to point out—before Cape May doctors rise in wrath—that the high death rate in Cape May is, in a sense, a tribute to its salubrious climate. Apparently many persons of retirement age go to Cape May because it is so happy a place. Naturally the death rate among annuitants has to be higher than it is among newly-weds. Industrial Middlesex cannot, therefore, be honestly compared with bucolic Cape May. Counties with death rates in excess of 12 were Atlantic, Cape May and Ocean. Counties with death rates under 10 were Bergen, Burlington, Middlesex, Salem, Somerset and Union.

(Continues overleaf)

If anybody wants to make anything of it, Cape May has the highest *marriage* rate in New Jersey as well as the highest death rate. The average marriage rate for the state is 8.2 weddings per thousand human beings. In Cape May, the rate is 9.4. Counties with rates in excess of 9 are: Cape May, Hudson and Ocean. The lowest marriage rate was in Burlington: 6.3 compared with the state average of 8.2. Other counties with marriage rates under 7 are Salem and Somerset. Marriages are credited to the county where the ceremony takes

place. A high marriage rate may reflect the popularity of the county's clergy rather than the predatoriness of its girls.

While they were releasing these figures, the Health Department also made a census estimate. They believe that our state now has 5,006,000 people in it, not counting Philadelphians summering at Atlantic City. New Yorkers taking a dip at Asbury Park or Congressional investigators at Fort Monmouth. The county census ranges from 36,000 in Sussex County to 933,000 in Essex.

Woman's Auxiliary • • •

PRESIDENT'S MESSAGE

Mrs. Paul E. Rauschenbach

As we begin this twenty-eighth year of our existence I wish to express greetings to each of you as members of the Woman's Auxiliary to The Medical Society of New Jersey.

Certainly all of you will wish to join me in thanking our hostess county, Atlantic, and her many charming women for a most enjoyable Convention. Everything that could be done for our comfort and pleasure was planned—and more too.

As your President I shall devote myself to the best of my ability to the welfare and interests of our Auxiliary. I trust that each member will work with me sharing her ideas and offering her advice. The Auxiliary as a whole will progress just as far as each of its members progresses.

Our theme for the year should read "Know Your County and State Medical Societies and Serve Them Well." At times I wonder if we appreciate what we are an Auxiliary to. The history of our Medical Society is indeed interesting and should be reviewed. Just as we know relatively little of our New Jersey medical society, so do we fail to understand many of the services rendered to us and to the general public by the American Medical Association. Let us spend some time this year learning a little more about American medicine and its accomplishments so that we may bring this story to our various communities.

We earnestly request your attendance at the Fall Conference where materials to help you with these studies will be distributed. The program of the Conference will be presented in an

early issue by the Conference Chairman, Mrs. Andrew C. Ruoff, Sr. Be prepared to purchase the national *Handbook* and the national *Bulletin* as additional aids to the informed member. Constantly urge your friends to seek the authentic health information offered them in *Today's Health*. We will be working especially hard this year to increase our number of subscriptions.

Just as it is important for a County Auxiliary to have a program and work toward its accomplishment, so is it necessary for this program to be reported faithfully and carefully. To facilitate this reporting we are experimenting this year with Quarterly Reports to be submitted to the Annual Report Review Committee. This Committee will edit the material and use it to formulate the booklet which is issued to all county presidents at the Annual Convention. The State Chairmen will read these reports to make their reports to National. This will eliminate several requests to various county chairmen for a report on their activities. Then, too, the Central Office will have on file a concise review of what is taking place currently on the county level.

As we work together let us remember the importance of good fellowship. Let us plan meetings that will send our members away anxious to bring other women to subsequent meetings because of the pleasant hour they have shared. Remember that your suggestions are always welcome and that we stand ready to help you whenever you choose to write us a letter or to pick up your telephone.

Obituaries • • •

DR. HARRY ARONOWITZ

Dr. Harry Aronowitz died in Bayonne on July 27 after a brief illness. Born in Bayonne in 1906, he was graduated from the medical school of St. Louis University in 1932. He was secretary of the Bayonne Hospital Medical Board, past-president of the Bayonne City Medical Society, and secretary of the Hudson County Medical Society. Dr. Aronowitz was a general practitioner, and was active in the New Jersey chapter of the American Academy of General Practice.

DR. HERMAN BALDAUF

Dr. Herman Baldauf, a past president of the Warren County Medical Society died at his home in Belvidere on July 14. Born in Trenton, 67 years ago, Dr. Baldauf was graduated from the New York Medical College in 1913. He was in the medical corps of the U. S. Army during World War I and thereafter entered practice in Trenton. He became chief of the Ear, Nose and Throat Clinic at the McKinley Hospital in that city. Later he moved to Belvidere. There he was Warren County physician as well as chief medical examiner of the Belvidere school system. He was on the staff of the Warren Hospital in Philipsburg.

DR. KIRK E. BARB

Dr. Kirk E. Barb, Chief Medical Examiner of the Camden School System, died suddenly on July 22. Born in Arkansas in 1886, he was graduated from the medical school of the University of Oklahoma in 1915. After serving in World War I, he came to Camden where he practiced ever since. He was active in many civic, educational and medical organizations, and was a member of the Sons of the American Revolution.

DR. I. NORWOOD GRISCOM

One of New Jersey's most useful lives came to a close on July 29 with the death of Dr. I. Norwood Griscom. Born in 1880, he was graduated from Hahnemann in Philadelphia in 1904. Only last year, Hahnemann awarded him a certificate of special distinction. His earlier medical activities were in Morris County, where he practiced in Boonton. He was a member of the selective service board, a medical examiner for the Department of Labor, president of the Kiwanis Club, chairman of the local Red Cross, and medical director of civilian

defense. In south Jersey he was interested in the development of the Port of Philadelphia, and was chairman of the development committee of the Port Authority there. He was recognized as a pioneer in the eventually successful move to span the Delaware River with a bridge for automobiles. He was a member of the original Delaware River Joint Commission as early as 1916.

DR. THOMAS E. MANLY

On July 13, Dr. Thomas E. Manly died after a short illness. Dr. Manly was active in civic as well as in medical affairs. In 1931 he was a member of the New Jersey State Assembly and in 1933 he was sheriff of Passaic County.

Born in New York City in 1897, he received his M.D. degree from Fordham in 1921. After an internship at the Paterson General Hospital that year, he elected to remain in that city, and soon became prominent in both medical and political circles. Although always interested in general practice, Dr. Manly devoted much of his time to surgery, and was on the surgical service of the Paterson General Hospital at the time of his death.

DR. LLOYD SALTUS

On June 19 Dr. Lloyd Saltus died at his home in Brookside. Born in 1909, Dr. Saltus was graduated from Columbia University's College of Physicians in 1935. After an internship in New York City and a residency at Massachusetts General Hospital, he opened his office in Morristown. Except for his three years of active Army service, he was in practice in Morristown from 1939 until his recent illness. He was on duty with the invasion forces in Europe, participating in both the Battle of the Bulge and the Normandy invasion.

DR. ABRAHAM SCHULMAN

Dr. Abraham Schulman, past-president of the staff of Christ Hospital, Jersey City, died at that hospital on August 6. Born in New York in 1899, he was graduated from Long Island Medical College in 1920, and after interning at North Hudson Hospital in Weehawken, he opened an office in Union City in 1922.

Dr. Schulman was a gynecologist and obstetrician and a frequent contributor to the literature in both specialties. He was on the staff of the Postgraduate Hospital in New York, the Margaret Hague and the Christ Hospitals in Jersey City.

Announcements • • •

Office Procedures for the General Practitioner

Saturday, September 25, is the date, Essex House (Newark 5, N. J.) is the place, and 9:00 a.m. is the time for the Symposium on Office Practice. Sponsored by the New Jersey Academy of General Practice, the program consists of two parts.

Morning Session. Harry Taff, M.D. is the moderator. Dr. Arthur Master will describe his two-step test for cardiac efficiency. Seymour Gray will discuss gastritis. Then there will be informal questions and answers from the floor.

Luncheon. Under chairmanship of Dr. Vincent Campana, a special luncheon will be held at the Essex House, starting at 12 noon, terminating at 1:40 p.m.

Afternoon Session. Under the gavel of Aaron Horland, this session will run from 2 p.m. to 5:30 p.m. with a coffee break at 3:20. Bernard Alpers will outline the routine neurologic examination for the general practitioner, and he will be followed by Robert Greenblatt, who comes from Augusta, Georgia to discuss hormone therapy in office gynecology. After the coffee break, the session will run the gamut from the eyes to the rectum. Arthur Bedell will discuss ophthalmic manifestations of general disease. Neil Swinton will deliver helpful hints on office proctology.

Credit for six hours formal study is allowed by the Academy of General Practice for attendance at this symposium. Lederle Laboratories is the co-sponsor. A special program has been provided for the wives which includes a luncheon, a cocktail party and a card party.

For further information, write to Dr. R. R. Chamberlain at 30 Lenox Place, Maplewood, N. J.

Gastro-Intestinal Cancer Conference

Reservations are still available for participation in the Round Table on Gastro-intestinal Cancer to be held at Memorial Center in New York on November 12. The discussion begins at 9:30 a.m. and terminates promptly at 1 p.m. It will be held at 444 East 68 Street. To confirm your reservation, telephone TRafalgar 9-3000 and ask for extension 593; or write to

Clinical Director, Memorial Center at the 68th Street address.

American College of Gastro-Enterology

The American College of Gastro-Enterology (formerly the National Gastro-Enterologic Association) will hold its next convention in Washington, D. C., October 25, 26 and 27. "Twenty-five years of the Gallbladder Controversy" will be one of the special features of the meeting. Another will be the 3-day graduate course in gastro-enterology, piloted by Dr. O. H. Wangenstein and Dr. I. Snapper. The course begins October 28. Copies of the program and further information can be obtained from the College at 33 West 60 Street, New York 23, N. Y.

Proctological Meetings

The Philadelphia Proctological Society announces a three-panel meeting to be held at the building of the County Medical Society, 2145 Spruce St., Philadelphia on Thursday evening, September 23 at 8:30 p.m. One panel discusses anorectal infection, another hemorrhoids and procidentia. The third panel will be on tumors of the rectum and colon.

Institute of Dental Medicine

The Institute of Dental Medicine is meeting at the Desert Inn, Palm Springs, California, October 31 to November 4, 1954. The faculty will consist of:

William A. Albrecht, Ph.D., University of Missouri.

Charles H. Best, M.D., University of Toronto.

Gordon M. Fitzgerald, D.D.S., University of California.

Maynard K. Hine, D.D.S., Indiana University.

Ernest Jawetz, M.D., University of California.

Joseph P. Weinmann, M.D., University of Illinois.

Seminar lecturers will participate in a round table on the application of their subject to dental medicine. Applications and full information may be secured from Miss Marion G. Lewis, 2240 Channing Way, Berkeley 4, California.

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Current Therapy, 1954. Latest Approved Methods of Treatment for the Practicing Physician. Edited by Howard F. Conn, M.D. Pp. 898. Philadelphia and London, W. B. Saunders Co., 1954. (\$11.00)

Current Therapy, 1954, follows diligently in the path blazed by its predecessors of 1949 through 1953. It gives short, concise data and recommendations for therapy in a readily available form. Dr. Conn and his editorial board have again revised their roster of contributors, thereby producing a difference of view with respect to previous volumes and to some degree within the same volume in relation to therapeutic approach. The text is excellent technically. The index is extremely complete. It is of interest to note that the book conforms to the familiar pattern of growth that one sees in a healthy, enthusiastically flourishing youngster by increasing its size—this year to 898 pages—a 7.5 per cent growth since 1953. It answers the purpose of a simple, succinct therapeutic reference guide admirably.

HENRY GREEN, M.D.

The Meaning of Social Medicine. By Iago Galdston, M.D. Pp. 137. Cambridge, Mass., Harvard University Press, 1954. (\$2.75)

In this small Commonwealth Fund book Dr. Galdston explains what social medicine is and what it can accomplish by orientation toward the achievement of health rather than the cure of disease. He is critical of the ultimate social and biologic effects of curative medicine. He asserts that "curative medicine has largely exchanged morbidity for mortality." That is, while it "cures" disease, it does not make the ailing person healthy. He holds that the extension of curative medicine, whether by government or by other agencies, will complicate rather than resolve the social and economic burdens of sickness. He believes that the major factors in the problem of medical care are not the economic and administrative (although they are important) but rather the nature of the medical care provided. He would place on society and on medicine the responsibility, not merely to cure the individual's disease, but to help him attain effective health. He suggests a reorientation of medical education to focus the students' attention upon life, health, and the full development of potentialities rather than upon disease, abnormality, and death.

There is an addendum: "Social Medicine in England"—a final chapter of 15 pages; and a bibliography of 90 references.

HAROLD M. GOETTEL

You and Your Allergic Skin (24 pages); Is Your Child Allergic? (23 pages). Pamphlets. By Herman Hirschfield, M.D. New York, Nelson House, 1954. (25 cents each)

The idea behind these pamphlets is an excellent one; to inform patients about their illnesses. Unfortunately, most of us do not have the time to sit down with our patients and explain the cause of their symptoms or the reasons for treatment. I do not think, however, that in 23 pages you can get much information across. Sometimes for the sake of brevity, you are left with the wrong impression. For example, if you read the treatment of hives on page nine of one of these pamphlets, you would believe that injections with the offending food or drug give you a good chance of developing an immunity to the allergen. Actually, only inhalants give good results with hypo-sensitization injections; and inhalants are only rarely a cause of hives.

Dr. Hirschfield writes in a readable manner and the cartoons on the covers of the pamphlets are excellent.

FRANK L. ROSEN, M.D.

A Manual of Tropical Medicine. By Thomas T. Mackie, M.D.; George W. Hunter, III, Ph.D.; and C. Brooke Worth, M.D., The Rockefeller Foundation, Second Edition. 907 pages with 304 illustrations, 7 in color. Philadelphia, W. B. Saunders Company, 1954. (\$12.00)

Recent events have focused attention on parts of the world where tropical diseases are endemic. Recent wars, speed of transportation and shifting of populations have brought many of these maladies to our own doorstep. Many of them are seen more or less frequently or must be considered in the differential diagnosis of many obscure diseases.

The authors have been assisted capably by 24 collaborators distinguished in their respective fields. They have prepared new chapters on such diseases as the virus encephalitides, rickettsialpox, leprosy, nutritional disease, the harmful effects of heat, etc. Other chapters they have revised completely, including those on the dysenteries, the rickettsial diseases, malaria, filariasis and laboratory technics. Both the superficial and the systemic fungus diseases are well covered.

Though the subject matter is comprehensive, the book makes for easy and interesting reading. Part of this is due to dividing the book into sections, headings and sub-headings so that it is easy to locate any subject quickly. The illustrations are

excellent and include many schematic drawings and charts which do much to clarify the subject material. The book is printed with clear type on good paper.

All in all, this is a veritable storehouse of information on tropical diseases and will be a valuable addition to any physician's library.

FREDERICK C. LICKS, M.D.

Surgical Forum. Proceedings of the Clinical Congress, American College of Surgeons, Chicago, October, 1953. Pp. 752. Philadelphia, Saunders, 1954. (\$10.00)

The Surgical Forum Committee of the A.C.S. should be congratulated for bringing to the profession the proceedings of the Clinical Congress. Those who attend these meetings know the value of the material presented. It is fortunate that those who are unable to attend are now given the opportunity of becoming acquainted with the surgical research being carried out in this country.

The ten sections of this volume, each headed by a foreword from a noted surgeon, cover a wide range of subjects. Many of the papers are written by men whose names are new in the field of surgery. One of the purposes of the College is to encourage young men who are doing research and to provide a forum for the presentation of their work.

The individual papers are well prepared, not burdened by too many references, and easily read. This reviewer can assure the reader he will enrich his surgical knowledge if he thumbs through this book from time to time.

HENRY REICH, M.D.

Song of Life With Variations. By Henry Ameroy Hartwell, M.D. Pp. 370. Boston, Bruce Humphries, Inc., 1954. (\$5.00)

New Jersey's beloved medical octogenarian, Dr. Hartwell, here assembles a collection of his verse, of his popular profiles of disease and of his essays. One section, entitled "What's Wrong With Me?" lists a hundred syndromes from Abortion to Yellow Fever. It is an alphabetical arrangement in which "Early Syphilis" is listed in the "E's" between Duodenal Ulcer and Ectopic Pregnancy. Here are some quotes from this section: mental shock is a cause of abortion; green sickness is a cause of acne; irregular meals are a cause of appendicitis; lumbago is a synonym for "backache sacroiliac disease"; a cause of this condition is sagging abdomen. One etiologic factor in neuralgia is general debility of the nervous system. It may also be caused by neuropathic heredity. Or by green sickness. Heredity causes 77 per cent of cases of paranoia. The cause of pellagra is unknown but a dietary fault with "insanitary surroundings" is believed to be a factor.

The poetry is largely medically centered. Examples: "The staphylococcus albus and his cousin

aureus dig deep into your tender skin promoting boils you cuss." (Get it? The last syllable of aureus rhymes with cuss). Or, "And when the air within your lungs fills up with poisons from the pneumococcus' ruthless way, use oxygen and rum." Here "rum" rhymes with "from."

Also included is a 55-page clinical account of Uncle Sam during the depression, seen as if he had an illness . . . complete with case history and clinical records. Though a bit tedious after the first five pages, it is witty in spots, and there are only fifty additional pages after the first five.

HENRY A. DAVIDSON, M.D.

Diencephalon: Autonomic and Extrapyrimal Functions. By Walter Hess, M.D. New York, 1954. Grune and Stratton, Pp. 79. (\$4)

In this somewhat esoteric work, Walter Rudolf Hess, Nobel Prize laureate, reports his now famous experiments on cats. Using a special needle electrode which could be plunged into brain tissue, he studied the effects of stimulation at various levels. The present slim monograph is a report of the effects of stimulating the diencephalon. Both the autonomic and the motor (extra-pyramidal) effects are tabulated and interpreted. The author's thesis about muscle system dynamics is developed. The book closes with a chapter on the future of research in neurophysiology. The text is well illustrated, but it is beyond the field of interest of the clinician. It will furnish a half hour of thought-provoking reading to the neurophysiologist or to the advanced biologist. That rare practitioner who wants and can grasp a solid physiologic substrate to practice will also find the book interesting.

HERBERT BOEHM, M.D.

Kindergarten in the Kitchen. By Polly Culbertson. Pp. 64. Published 1954 by the Bancroft School, Haddonfield, N. J. (\$1.00)

In this gallant and effective book, a mother tells how she used simple home equipment for the training of a retarded child. The book is written with wisdom, with grace and with a poignant good humor. Many a parent must be disheartened by the expense of a private school, by the frightfully long waiting lists in the state schools and by the unwillingness or inability of the city school to receive and help the retarded child. To such a parent this colorful little book will be a Godsend. It tells how one mother contributed conspicuously to the training of a child, using no more than every-day home equipment. The pediatrician, the psychiatrist and the family doctor will want to know about this book so that he may recommend it. And, incidentally, it will provide him with excellent material for talks to the public on the general subject.

SAMUEL POLLOCK, M.D.

Supplied by New Jersey Trudeau Society

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

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No. 9

Bed Rest in the Treatment of Pulmonary Tuberculosis

A Twenty-Year Follow-Up Study of 377 Patients

By Albert I. DeFriez, M.D., William E. Patton, M.D., Edward J. Welch, M.D., and Theodore L. Badger, M.D., *The New England Journal of Medicine*, January 14, 1954.

Recent advances in the treatment of pulmonary tuberculosis warrant a critical review of the place of bed rest in the treatment of this disease. Bed rest, of varying character and duration, has been the cornerstone of treatment for many years. New drugs and improved surgical technics have made a strict evaluation of the older methods of treatment necessary in order to have a therapeutic baseline by which the newer procedures may be judged. Today the treatment of even minimal tuberculosis without chemotherapy is unusual so the effects of bed rest *per se* can be determined only by a retrospective study such as this.

Since 1930 the Channing Home (Boston) has used strict bed rest as the basis of treatment, with additional forms of therapy as indicated. There has always been a conflict of attitudes toward the treatment of the tuberculous patient, necessitating a compromise between the maximum amount of rest needed by those acutely and chronically ill and the physiologic benefits of exercise for the normal body. This conflict still prevails and probably accounts for the wide variations in the regimens of rest advised.

The records of all patients admitted to the Channing Home for Tuberculosis from 1930 through 1944 were reviewed for this study. This institution is a 29-bed voluntary hospital founded in 1857 for the treatment of chronic disease in women. Since 1900, however, only patients with pulmonary tuberculosis have been admitted, and

they, with few exceptions, are placed on strict bed rest. When clinical signs of active disease are absent, when the sputum is converted and serial X-ray films show no change, bathroom privileges are allowed, then increasing activities. Eight weeks before discharge, patients are placed on exercise increasing by daily increments of five minutes, until, having reached four hours a day out of bed, they are discharged to continue treatment under the care of their physician at home.

All X-ray examinations of the lungs were reviewed, but those taken at the time of admission, six weeks later, four months after admission and at discharge were regarded as an index of progress for the study. These were evaluated in retrospect by a panel of three or more staff members. Following discharge chest films taken in the period up to five, six to ten, 11 to 15 and 16 to 20 years were compared to evaluate the patient's subsequent progress.

The incidence of relapse or progression of disease under sanatorium treatment and of relapse after discharge was selected as an index of the success or failure of treatment. No attempt was made to differentiate a "relapse" from a "progression." The few patients who signed out against advice did not significantly affect the results. Patients (53 of the 377 studied) who were granted bathroom privileges on admission had small lesions and were afebrile. Statistical analysis of this group revealed that it was justifiable to consider them with the main group of patients. During the period of this study 434 patients were admitted to the institution. Seven of these were never proved to have had active tuberculosis, 16 were transients

and 34 were readmissions and were evaluated only on the basis of their original admission.

A total of 377 cases thus became available for study. Of these, 156 were transferred from the Channing Home to other sanatoriums. This group was included because, on review, it was apparent that their relapse rate did not differ significantly from that of the 221 patients who remained at the Channing Home during their treatment. Follow-up data and statistical analyses were based on the total hospitalization of 377 patients. The median age of the patient population was 28.3 years. The average hospital stay for all cases was 15.4 months. Patients given thoracoplasty and pneumothorax had a long period of hospitalization (a mean of 22.5 months and 18 months respectively) probably because at the time of admission they had sufficiently acute or advanced disease to warrant extended bed rest before surgery.

Advanced disease accounted for 76 per cent of all admissions while 16 per cent were classified as having minimal disease. The remaining eight per cent were patients whose chest films could not be classified for a variety of reasons.

All living patients were followed for a minimum of five to a maximum of 20 years; 58 per cent were alive at the end of the follow-up period, and 23 per cent had died of tuberculosis. The term "relapse" is used to designate any patient who showed a progression of disease after leaving the institution, whatever the interval after discharge. There was a high mortality from tuberculosis among those who relapsed. Of 95 patients who relapsed 31 per cent finally recovered, and six per cent died of causes other than tuberculosis. The others are dead of tuberculosis, have relapsed again or are still on restricted activity.

The highest annual relapse rate occurred during sanatorium treatment due to the 48 patients, many of them severely ill when admitted, who died in the institution. The "cumulative relapse rate" reveals that, of 100 persons, 50 had either progressed in the sanatorium or relapsed after discharge by the end of 20 years. The cumulative relapse rate corrected for the 48 patients who

died in the institution is 42 per cent for the 20-year period.

No matter what the stage of the tuberculosis was or what treatment applied, the cumulative relapse rate is high. The 20-year cumulative relapse rate is 33 per cent for patients treated with strict bed rest plus thoracoplasty, 39 per cent for patients with minimal tuberculosis treated with strict bed rest and 54 per cent for patients with moderate disease treated with strict bed rest. The relapse rate for advanced tuberculosis treated by every available means was 56 per cent.

Bed rest must be considered a specific form of therapy along with other procedures such as pneumotherapy, chemotherapy and definitive surgical technics. In this study specific treatments are hardly comparable with each other on a strictly statistical basis; but in all forms of therapy there is reason to be dissatisfied with the subsequent high rate of relapse. A recent evaluation of modified bed rest in minimal tuberculosis, showed that the younger the patients, the more newly acquired the disease and the greater its extent, the more likely it was to relapse over a period of time. The present study indicates that *strict bed rest* was no more dependable than *modified rest* as treatment for minimal tuberculosis. It seems preferable to utilize both chemotherapy and occasionally surgery, in addition to bed rest in minimal disease that is so unpredictable and so prone to relapse.

The real effect of bed rest is still unknown, yet its value in active stages of tuberculosis remains widely accepted. It may be possible to shorten the period of bed-rest when used with anti-tuberculous drugs. Greater emphasis on indoctrination of the patient will be necessary, and rehabilitation will be begun early in the long-term chemotherapy. Meanwhile, while new therapies are being explored, bed rest should remain the starting point of management. Finally it should be noted that the unequivocal value of anti-tuberculous drugs makes treatment of active tuberculosis by bed rest alone hardly justifiable. The problem of the future will be to determine how much bed rest, strict or modified, is advisable in addition to drug therapy in the management of each patient.

NEW JERSEY TRUDEAU SOCIETY
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Dramamine's® Effect in Vertigo

Dramamine has become accepted in the control of a variety of clinical conditions characterized by vertigo and is recognized as a standard for the management of motion sickness.

Vertigo, according to Swartout, is primarily due* to a disturbance of those organs of the body that are responsible for body balance. When the posture of the head is changed, the gelatinous substance in the semi-circular canals begins to flow. This flow initiates neural impulses which are transmitted to the vestibular nuclei. From this point impulses are sent to different parts of the body to cause the symptom complex of vertigo.

Some impulses reach the eye muscles and cause nystagmus; some reach the cerebellum and skeletal muscles and righting of the head results; others activate the emetic center to result in nausea, while still others reach the cerebrum making the person aware of his disturbed equilibrium. *Vertigo may be caused by a disease or abnormal stimuli of any of these tissues involved in the transmission of the vertigo impulse, including the cerebellum and the end organs.*

A possible explanation of Dramamine's action is that it depresses the overstimulated labyrinthine structure of the inner ear. Depression, therefore, takes place at the point at which these impulses, causing vertigo, nausea and similar disturbances, originate. Some investigators have suggested that Dramamine may have an additional sedative effect on the central nervous system.

Repeated clinical studies have established Dramamine as valuable in the control of the symptoms of Ménière's syndrome, the nausea and vomiting of pregnancy, radiation sickness, hypertension vertigo, the vertigo of fenestration procedures, labyrinthitis and vestibular dysfunction associated with antibiotic therapy, as well as in motion sickness.

Any of these conditions in which Dramamine is effective may be classed as "disease or abnormal stimuli"* of the tissues including the end organs (gastrointestinal tract, eyes) and their nerve pathways to the labyrinth.

Dramamine (brand of dimenhydrinate) is supplied in tablets of 50 mg. and liquid (12.5 mg. in each 4 cc.). It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.



The site of Dramamine's action is probably in the labyrinthine structure.

*Swartout, R., III, and Gunther, K.: "Dizziness:" Vertigo and Syncope, GP 8:35 (Nov.) 1953.

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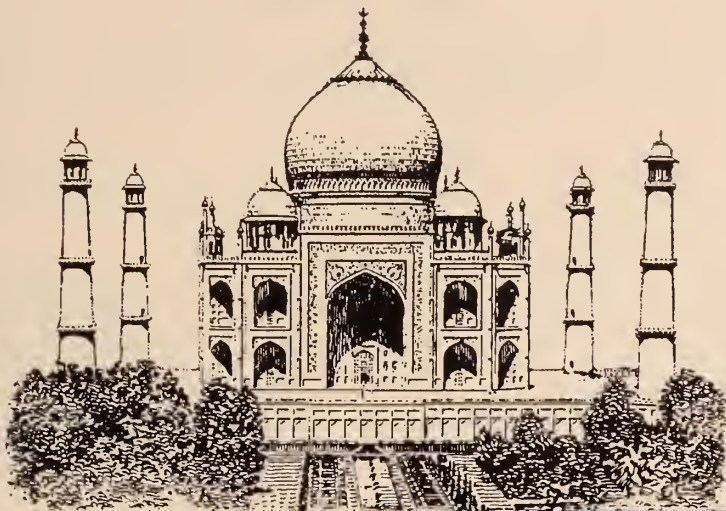
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1. Malleson, J.: *Lancet* 2:158 (July 25) 1953. 2. Goldzieher, M. A., and Goldzieher, J. W.: *Endocrine Treatment in General Practice*, New York, Springer Publishing Company, Inc. 1953, p. 23.

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1. Shuman, C. R., and Wohl, M. G.: Nutritional Aspects of Heart Failure, *J. Clin. Nutrition* 2:5 (Jan.-Feb.) 1954.

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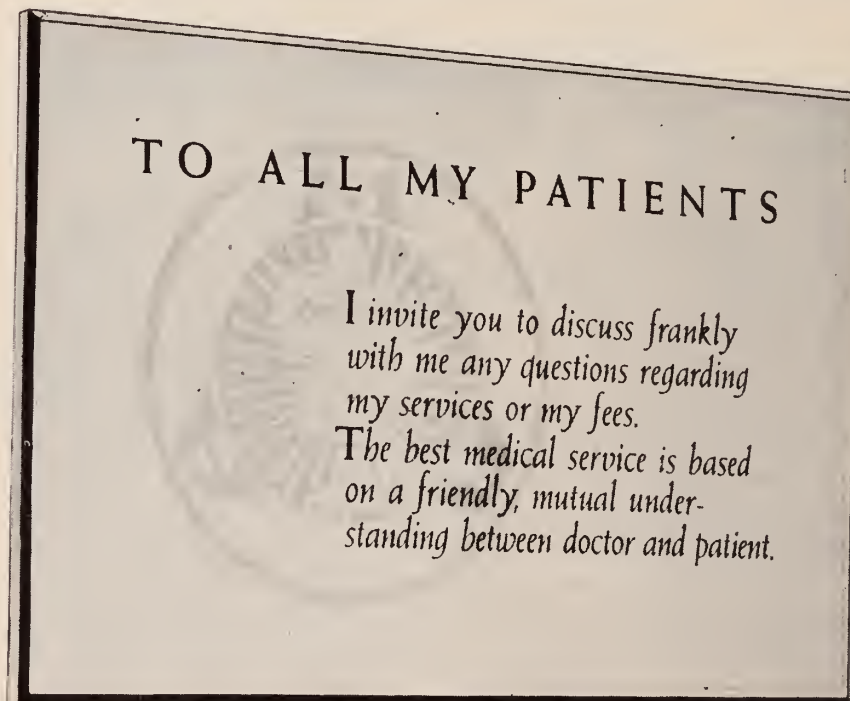
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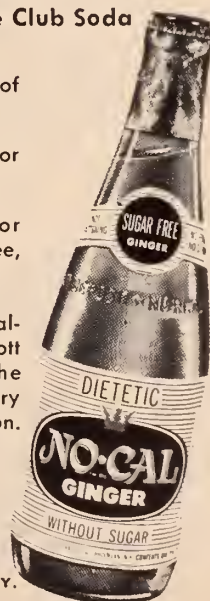
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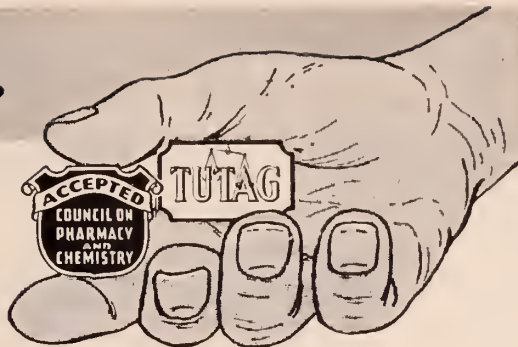
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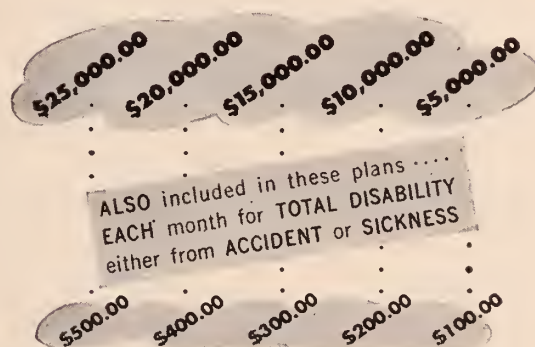
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- (1) Kirby, W. M. M.; Waddington, W. S., & Doornink, G. M.: Antibiotics Annual, 1953-1954, New York, Medical Encyclopedia, Inc., 1953, p. 285.
- (2) Finland, M., & Haight, T. H.: *Arch. Int. Med.* **91**:143, 1953.




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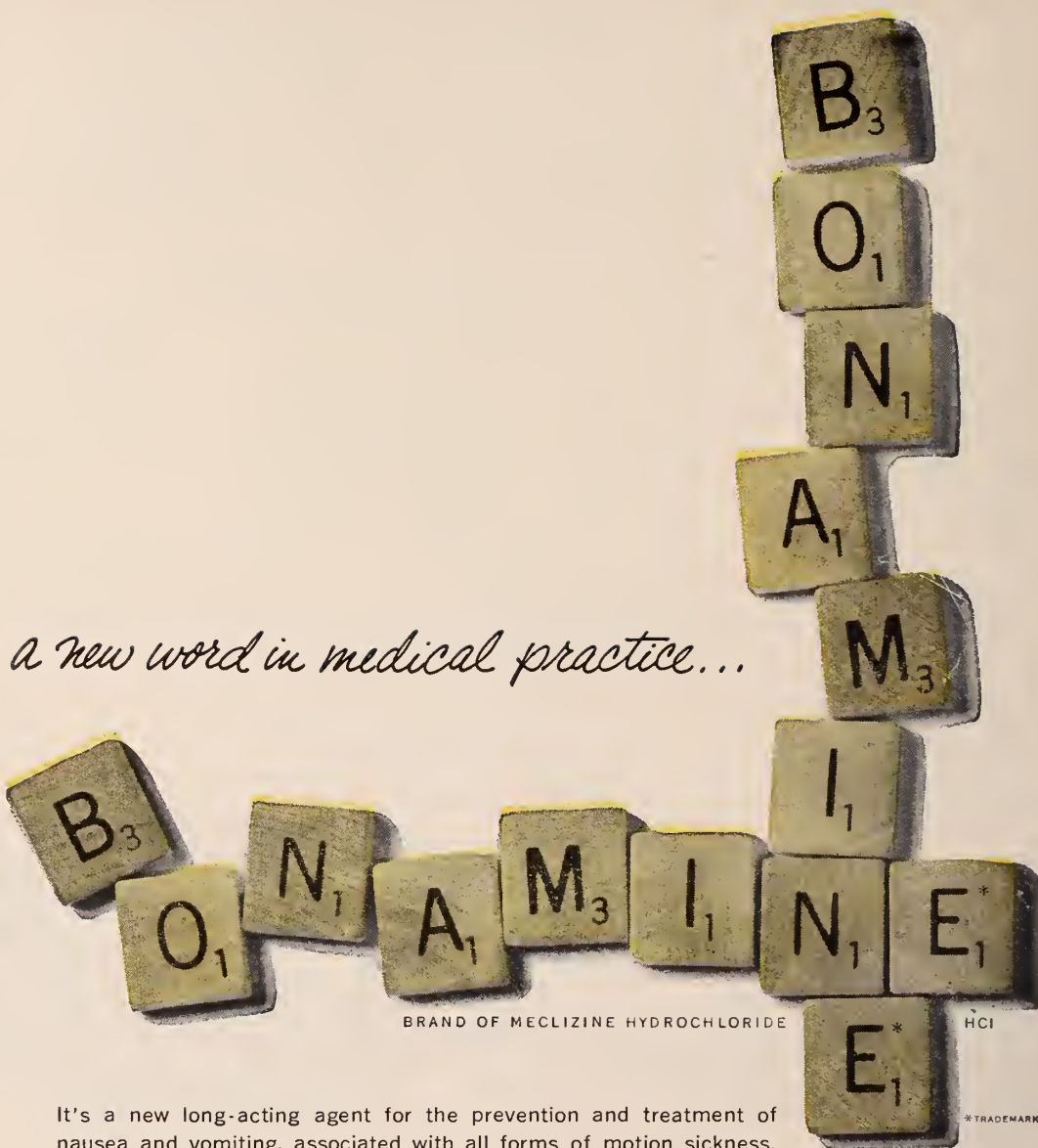


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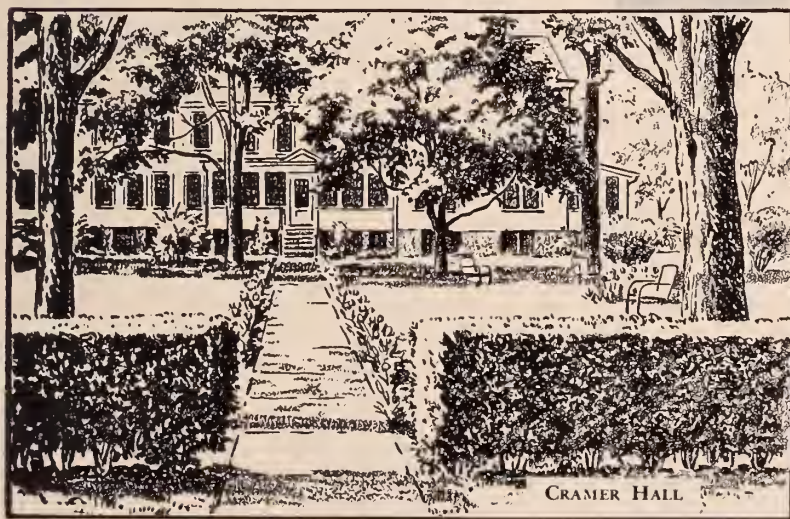
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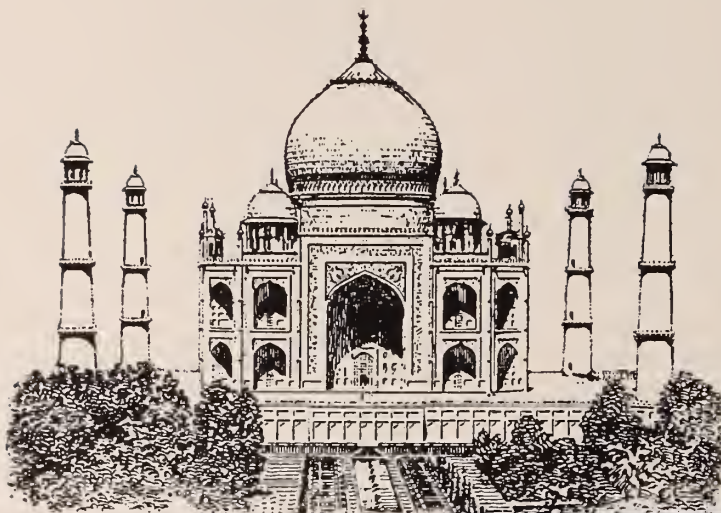


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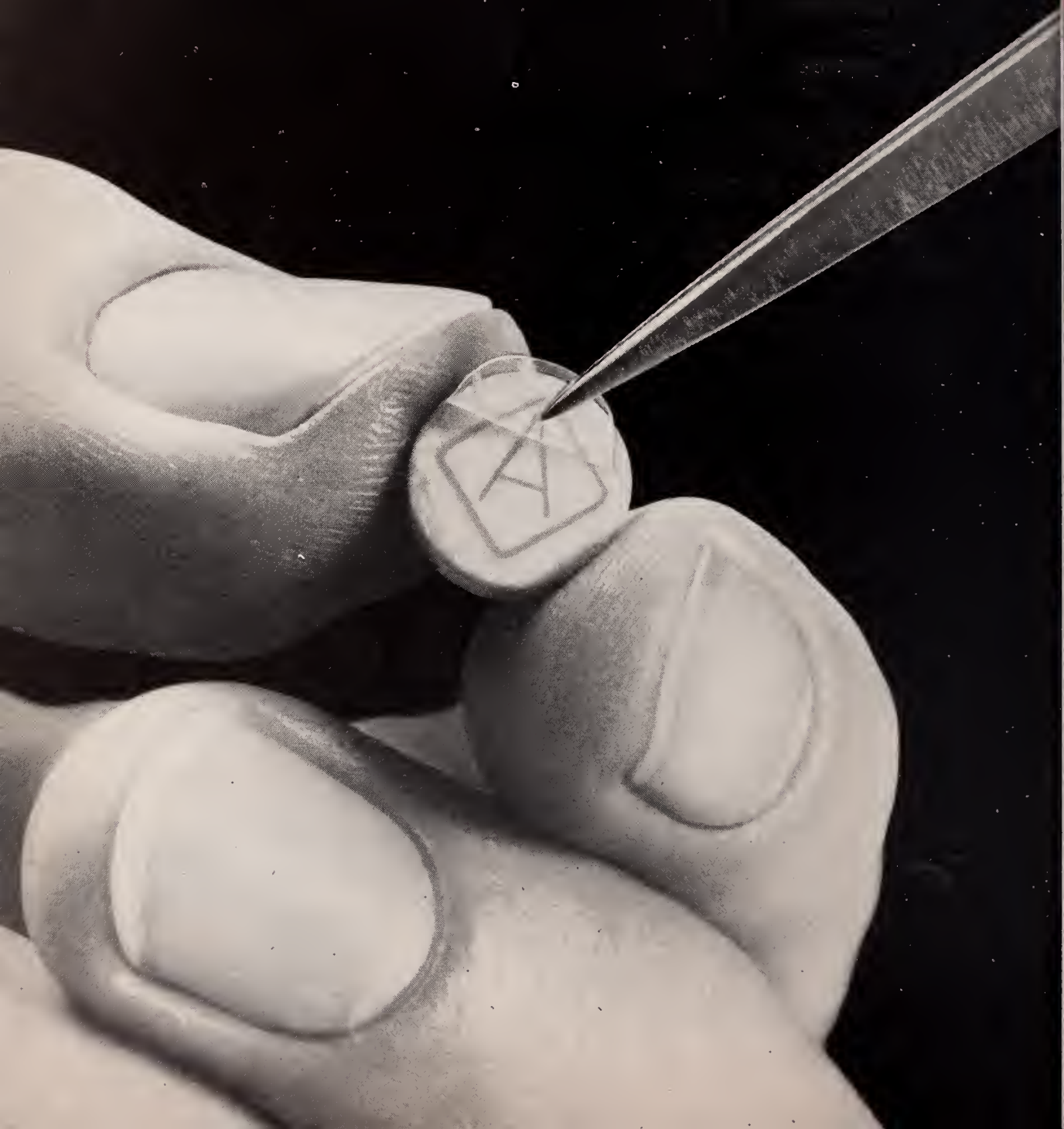
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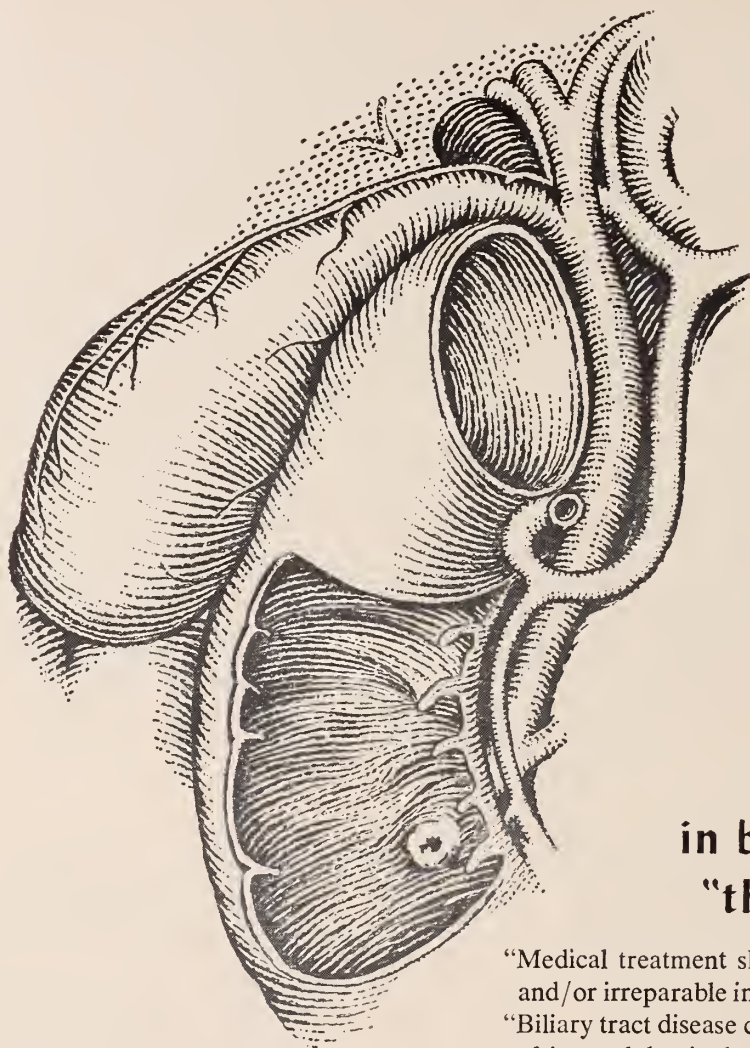
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1. Segal, H.: *Postgrad. Med.* 13:81, 1953. 2. O'Brien, G. F., and Schweitzer, I. L.: *M. Clin. North America* 37:155, 1953. 3. Beckman, H.: *Pharmacology in Clinical Practice*, Philadelphia, W. B. Saunders Company, 1952, p. 361.

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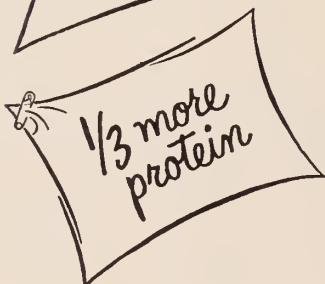
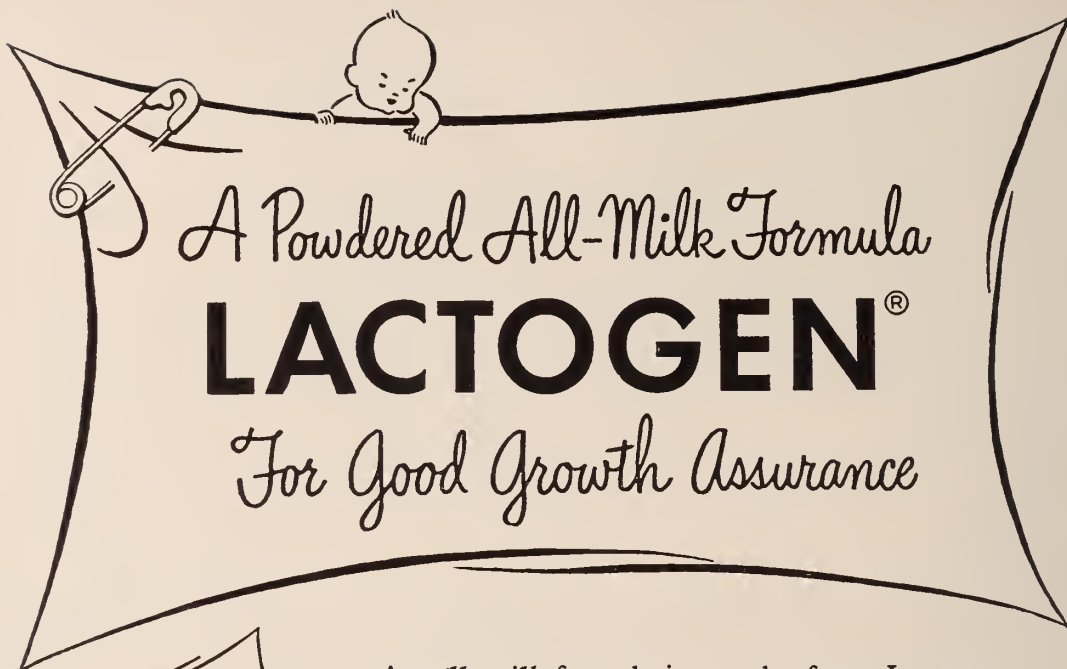
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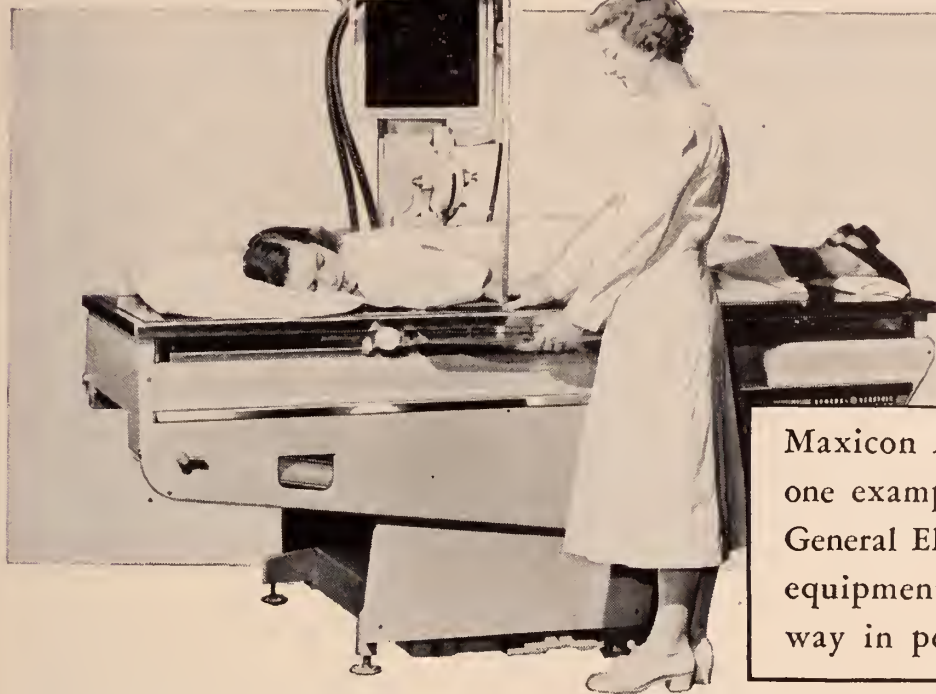
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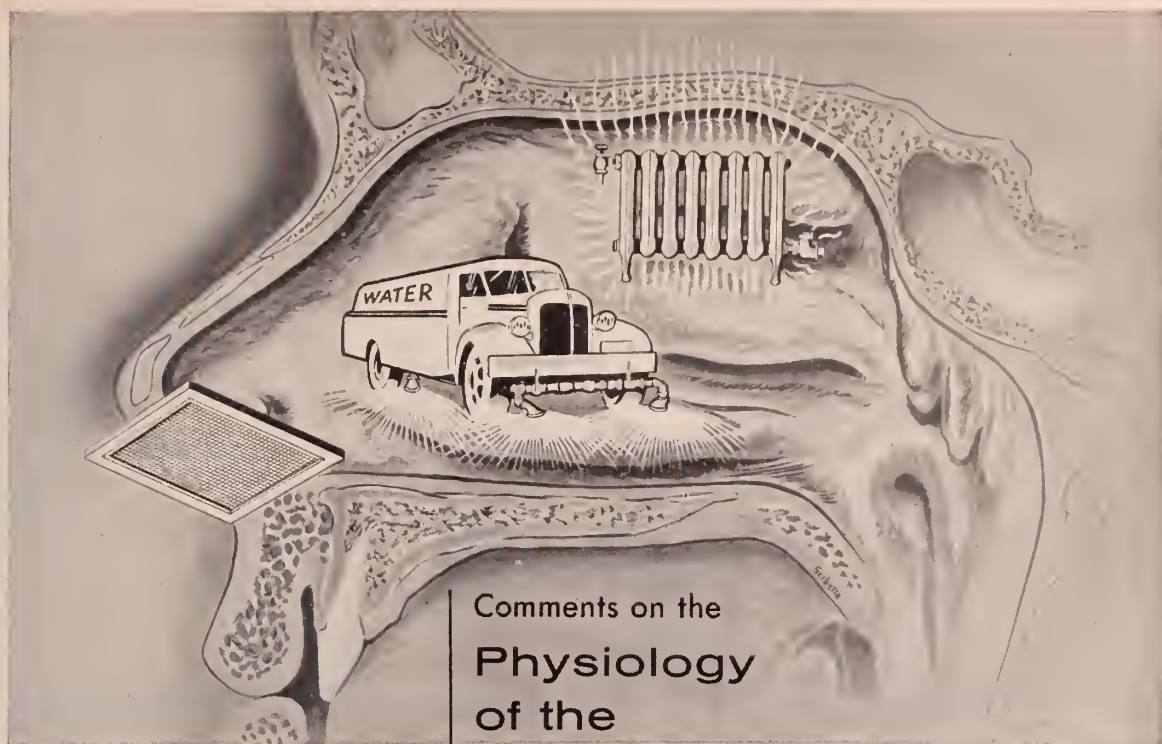
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Comments on the Physiology of the Upper Respiratory Tract

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In the common cold . . . when hypersecretion and mucosal swelling interfere with the normal aeration pattern, when abnormal mouth breathing is resorted to as a distress measure, relief can be obtained promptly with topical application of Neo-Synephrine hydrochloride. This potent vasoconstrictor is usually well tolerated — produces practically no sting or irritation on application to mucous membranes — even in infants.

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NOT ARTHRITIS BUT ARTHRALGIA...

If the patient complaining of aching joints is a woman between 37 and 54 years of age, it is highly possible that she is suffering from arthralgia rather than arthritis.¹ It has been estimated that arthralgia occurs in about 40 per cent of women with estrogen deficiency, and is exceeded in frequency only by symptoms of emotional or vasomotor origin.² In fact, arthralgia may be as indicative of declining ovarian function as the classic menopausal hot flushes.

Arthralgia, however, is just one of a vast number of distressing but ill-defined symptoms that may be precipitated by the loss of estrogen as a "metabolic regulator." Other good examples are insomnia, headache, easy fatigability, and tachypnea.

Because these symptoms sometimes occur years before or even long after cessation of menstruation, they are not always readily associated with estrogen deficiency, and the tendency may be to treat them with medications other than estrogen. Obviously, sedatives and other palliatives cannot be expected to produce a satisfactory response if an estrogen deficiency exists. Only estrogen replacement therapy will correct the basic cause of the disorder.

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1. Greenblatt, R. B., and Kupperman, H. S.: *M. Clin. North America* 30:576 (May) 1946. 2. McGavack, T. H., in Goldzieher, M. A., and Goldzieher, J. W.: *Endocrine Treatment in General Practice*, New York, Springer Publishing Company, Inc., 1953, p. 225.

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References: 1. Hollander, F.: Arch. Int. Med. 93:107 (Jan.) 1954
2. Deutsch, E.: Scientific Exhibit, Gastroscopy, Interim Session A.M.A., St. Louis, December, 1953



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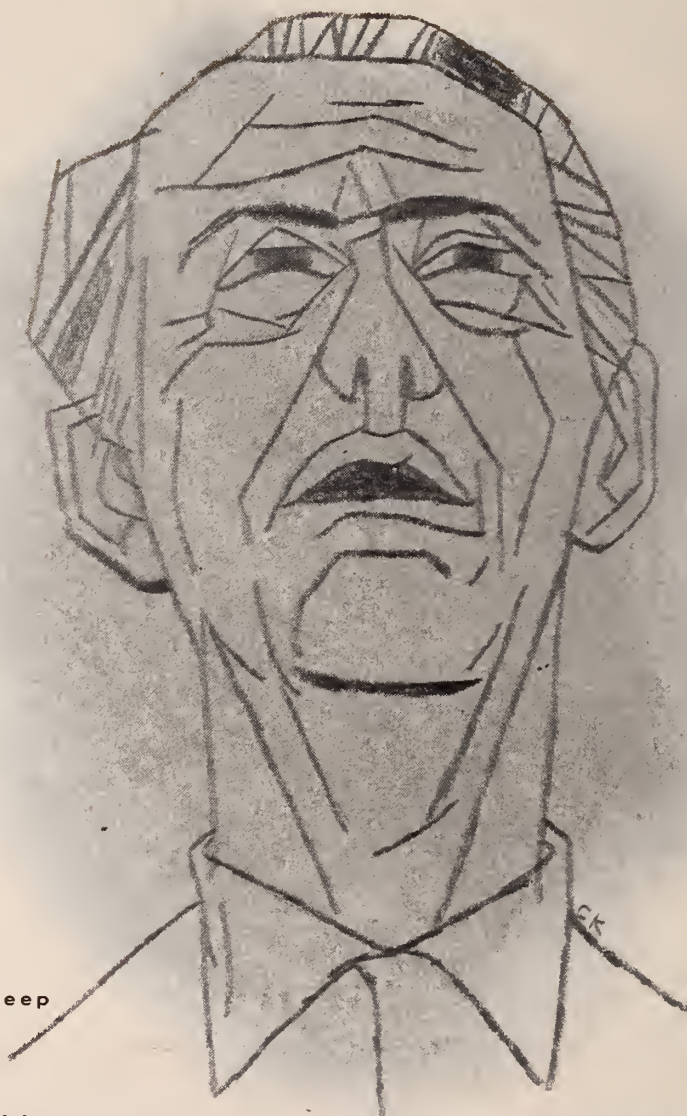
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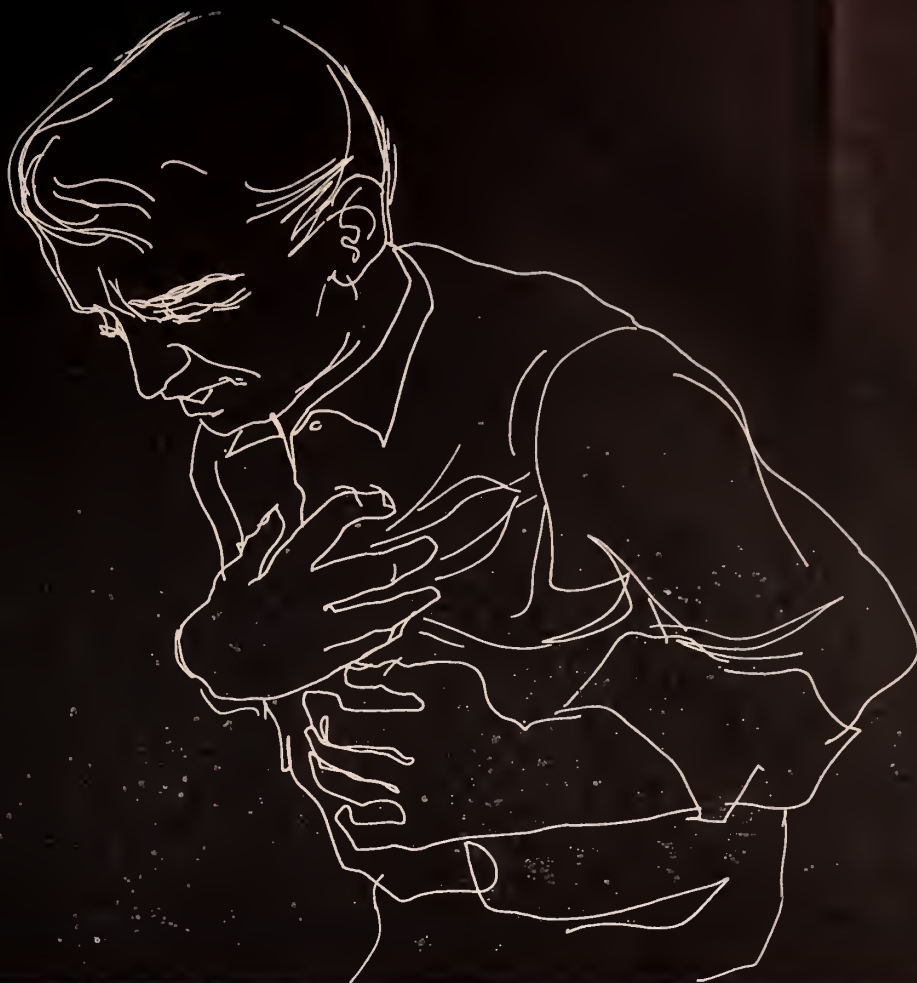
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1. *reduce the number of attacks in almost 80 per cent of patients²*
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1. Russek, H. I.; Urbach, K. F.; Doerner, A. A., and Zohman, B. L.: J.A.M.A. 153:207 (Sept. 19) 1953.
2. Humphreys, P., et al.: Angiology 3:1 (Feb.) 1952.
3. Plotz, M.: New York State J. Med. 52:2012 (Aug. 15) 1952.

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Vigilance Will Protect Against Diabetes

The week of November 14 is Diabetes Detection Week. This is a double-barreled drive. First, it aims at alerting the public to the possibility of this disease and urges it to submit to urinalysis. Second, it reminds the physician that diabetes is a silent disease. It lurks behind furunculosis and pruritus in the office of a dermatologist. It hides behind altered sensations and reflexes in the consulting room of a neurologist. It pops out through a cloud of albumen in the test tube of the urologist.

It is the primary responsibility of the medical profession to discover diabetes as early as possible. Poorly controlled diabetes will lead

to a high incidence of complications with resulting partial or total disability.

The New Jersey Diabetes Association in cooperation with the State Health Department has arranged an interesting program at the Academy of Medicine in Newark on October 27. This will acquaint the members of the profession with the latest advances in the field of diabetes. See page 445 this issue.

Every physician, regardless of specialty has a stake in diabetes control. Every citizen has a stake in it too. The physician-citizen thus has two duties here.

Mountainous Labors and Mouse-Like Results

Science, they tell us, is only applied common sense. Like the time the Army tried to figure out (scientifically) how to predict whether a soldier would work more efficiently in the arctic or in the tropics. They gave elaborate psychologic tests. They correlated efficiency at all climes with pulse, blood pressure, pH, metabolic rate, dandruff on the collar, liver function, and so forth. Mightily they labored and at last they found a formula. Now it was possible, well in advance of transferring the soldier, to determine whether he would do better in the tropics or better in the arctic.

How? By asking him whether he liked hot weather better than cold.

Again, consider the two and one-half year study of the Arthritis and Rheumatism Foundation. They had 282 patients with rheumatoid arthritis. The problem was to review the gamut

of drugs and see which gave most help to most patients. There were hormones, endocrines, vitamins and antibiotics. There were drugs distilled in the jungles of South America or extracted from the exotic plants of India. There were drugs of metallic origin, drugs of plant origin and wholly synthetic drugs. Results were checked, double-checked and cross-correlated. Indices were computed, coefficients of error and variance were calculated. After two and one-half years the report was finished. The most useful of these many esoteric drugs was found to be: aspirin!

In the field of losing weight, many a genius has discovered, after years of studious sweating and high-proof research, that the best way to lose weight is to eat less.

And so it goes. Without the leaven of common sense, science would float away until it lost itself in the stratosphere.

ROBERT A. McLANE, M.D.

Hillsdale

CHARLES C. HECK, M.D.

Syracuse, N. Y.

Combined Drug Therapy in Acute Upper Respiratory Infections

Oral penicillin is found to improve the effectiveness of the "APC" and antihistamine combinations traditionally used in the treatment of upper respiratory infections.

ACUTE undifferentiated infections of the upper respiratory tract are commonly designated as "colds" or "grippe." The local manifestations and probably also the etiologic agents are changeable, almost from day to day. Initially, there may be rhinorrhea and nasal obstruction, followed within a few days by purulent nasal discharge, "sore throat" and cough. The acute process at first may be confined to the nasal mucosa and subsequently extend to the paranasal sinuses or middle ear. At other times these infections may begin as non-exudative pharyngitis that soon gives rise to laryngotracheitis. Less commonly laryngotracheitis may be seen several days later as bronchopneumonia.

The protean character and indeterminate etiology of most acute upper respiratory infections usually render treatment difficult, especially in general office practice. In such cases, nonspecific remedies are commonly prescribed

for alleviation of symptoms. When antibiotic agents are also administered, the usual clinical objective is prophylaxis of bacterial complications rather than treatment of the primary infection. The frequency with which antibiotics should be administered prophylactically to patients with acute undifferentiated upper respiratory infections is determined by weighing the probable advantages against the possible side effects of such prophylaxis.

Long prescribed for symptomatic treatment in "colds" and "grippe" is the usual mixture of aspirin, phenacetin and caffeine. The usefulness and limitations of this remedy are well known to every physician. More recently, the antihistamines have come to be widely used in the common cold. Although antihistamines apparently do not abort or shorten the duration of colds, these agents often effect measurable relief of the allergy-like symptoms of acute rhinitis.¹ To allay both local and systemic symptoms that make up the syndrome of the common cold, antihistamines are frequently administered in combination with aspirin, phenacetin and caffeine.

1. United States Naval Medical Research Unit No. 4: The Prophylaxis and Treatment of Acute Respiratory Diseases with Antihistaminic Drugs. J. Lab. and Clin. Med. 36:555, (1950).

PENICILLIN-SUSCEPTIBLE organisms such as streptococci and pneumococci are prominent among causes of bacterial complications of the common cold. Penicillin is usually effective in the treatment of these complications. The efficacy of penicillin for prophylaxis has been clearly shown in extended studies relating to recurrences of rheumatic fever.^{2,3} It is difficult to evaluate short courses of penicillin for the purpose of preventing bacterial complications in acute undifferentiated respiratory infections. However, such prophylaxis appears to be sound clinical practice among patients who are particularly prone to develop more or less serious sequelae. Moreover, in acute and relatively mild streptococcal infections of the upper respiratory tract, the streptococcal etiology is often not apparent because of the absence of characteristic manifestations.³ In such cases, the administration of penicillin (intended to prevent bacterial complications) also serves the possibly unrecognized purpose of treating the primary infection.

The potential hazards of penicillin, administered to patients with acute undifferentiated respiratory infections, include the risk of hypersensitivity reactions and the emergence of penicillin-resistant organisms. With respect to the risk of sensitization, there is general agreement that *oral* penicillin has a low sensitizing potential.⁴ Prolonged oral administration for the prevention of streptococcal infections and recurrences of rheumatic fever rarely causes hypersensitivity or other untoward reactions.^{2,3} Concerning the question of induced bacterial resistance, only *Staphylococcus* appears to have acquired resistance to penicillin through gradual elimination of sensitive strains of this organism.⁵ The increase in the numbers of penicillin-resistant staphylococci is not great and has been magnified by studies in hospital cross-infections. In these studies, the high incidence of resistant organisms does not reflect the actual situation.⁶

The purpose of the present study was to compare the efficacy of certain combinations of drugs in patients with acute undifferentiated infections of the upper respiratory tract. The results of a preliminary evaluation of the same drug combinations have previously been re-

ported.⁷ The current study, concerned with the observation and treatment of a larger number of patients, is an extension of the earlier, preliminary evaluation.

MATERIAL AND METHODS

Two hundred and thirteen patients with acute upper respiratory infections were observed in the second series of tests. They were selected from among employees at two industrial plants, one at Syracuse, N. Y. and the other at Kenilworth, N. J.

Tablets of the following three drug combinations were tested:

1. Acetylsalicylic acid (150 mg.), phenacetin (120 mg.), and caffeine (30 mg.).
2. The above "APC mixture" plus an antihistamine agent, phenyltoloxamine dihydrogen citrate (25 mg.).
3. The above "APC-antihistamine combination" plus procaine penicillin G (100,000 units).

The tablets containing each of the three drug combinations were identical in appearance. They were identifiable to dispensary personnel only by code number. They were dispensed in random fashion to the patients selected for the investigation. The prescribed dose of each combination was two tablets three times a day, taken with water one hour before or two hours after each meal. Adjuvant measures were not recommended during the period of testing.

2. Massell, B. F.: Present Status of Penicillin Prophylaxis, *Mod. Concepts Cardiovasc. Dis.* 20:108, (1951).

3. Kohn, K. H. et al.: Prophylaxis of Recurrences of Rheumatic Fever with Penicillin Given Orally, *J. A. M. A.* 151:347, (1953).

4. Keefer, C. S.: Evaluation of Antibiotic Therapy, *Postgrad. Med.* 9:101, (1951).

5. Finland, M.: Clinical Uses of Presently Available Antibiotics, *Antibiotics Annual 1953-1954*, Medical Encyclopedia, Inc., New York, N. Y.

6. Welch, H.: (Editorial) The Antibiotic-Resistant Staphylococci, *Antibiotics and Chemotherapy* 3:561, (1953).

7. McLane, R. A.: Clinical Evaluation of Combined Drug Therapy in Acute Upper Respiratory Infections, *J. Med. Soc. New Jersey* 49:509, (1952).

Known cases of nasal allergy (hayfever, vasomotor rhinitis) were excluded from the study. All selected cases were initially classified according to the severity of symptoms. The disease was considered *severe* if the temperature was in excess of 100 and the patient had other symptoms of acute upper respiratory infection. The process was adjudged *moderate* when the temperature was less than 100 with only moderate congestion of the nasopharyngeal mucous membranes and moderate discharge. An infection was classed as *mild* when the patient was afebrile and had minimal objective signs of acute upper respiratory disease.

Correlation of severity of symptoms with treatment received is shown in Table I. Cases exhibiting moderate to marked symptoms comprised 80 per cent of the group that received the "APC-antihistamine-penicillin combination" and 62 per cent of those treated with the two other tablets.

CRITERIA OF RESPONSE

THE efficacy of treatment was measured by the degree to which subjective and objective symptoms were controlled at the end of 72 hours following the initial visit. If no subjective or objective symptoms remained at the end of the observation period, the therapeutic response was termed "*excellent*." If clinical manifestations of the disease were partly controlled, the response was considered "*incomplete*." When subjective and objective signs were unaltered or accentuated despite treatment, the response was called "*poor*."

TABLE I
CORRELATION OF CASE SEVERITY AND TREATMENT

Total		APC or APC with Antihistamine	APC with Antihistamine and Penicillin
		Number of Cases	
35	Severe	9 or 11%	26 or 20%
121	Moderate	43 or 52%	78 or 60%
57	Mild	31 or 37%	26 or 20%
213	Total	83 or 100%	130 or 100%

RESULTS

THE therapeutic results, expressed in terms of these criteria, are summarized in Table II. The response in the group receiving "APC" did not appear to be significantly different from the response in the group treated with "APC-antihistamine." The combined results in both these groups are compared with the response to the tablets containing penicillin in addition to "APC" and antihistamine.

An *excellent* response was observed in 65 per cent of the patients treated with "APC-antihistamine-penicillin." Only 13 per cent showed excellent response to the other two medications. There were 87 per cent *poor* and *incomplete* responses in the groups treated with the "APC" or "APC-antihistamine," while 35 per cent responded "incompletely" or "poorly" to treatment with the penicillin-containing tablets.

The therapeutic responses observed in the previous study of the three drug combinations are similar to those noted in the present study. However, the latest tests were made in two widely separated areas of the country during several seasonal waves of acute upper respiratory diseases. It is presumed that a greater variety of etiologic factors was encountered than in the earlier, preliminary study.

There were no objective signs of toxicity or unusual reactions in any of the patients studied. In the group treated with the penicillin-containing tablets, not one patient developed definite or suggestive symptoms of penicillin hypersensitivity. Complaints of mild nausea and "lightheadedness," which may have been causally or only coincidentally related to the medi-

TABLE II
RESULTS OF TREATMENT

		Number of Cases	
	Therapeutic Response	APC or APC with Antihistamine	APC with Antihistamine and Penicillin
95	Excellent	11 (13%)	84 (65%)
67	Incomplete	39 (47%)	28 (21%)
51	Poor	33 (40%)	18 (14%)
213	Total	83 (100%)	130 (100%)

cation, were made by occasional patients in all three groups.

SUMMARY AND CONCLUSIONS

1. A series of 213 industrial employees, with symptoms of acute undifferentiated upper respiratory infections, were treated with either one of three drug combinations. Eighty-three patients received tablets containing "APC" or "APC" and antihistamine. One hundred and thirty received tablets containing the "APC-antihistamine" combination plus penicillin.

2. Complete remission of clinical signs and

symptoms of acute upper respiratory infection was noted at the end of the 72-hour test period in 65 per cent of the patients treated with the penicillin-containing tablet. A similar response was observed in only 13 per cent of those treated with "APC" or "APC-antihistamine" tablets.

3. These observations confirm an earlier report⁷ that a tablet containing aspirin 150 mg., phenacetin 120 mg., caffeine 30 mg., phenyltoloxamine dihydrogen citrate 25 mg., and procaine penicillin G 100,000 units is an effective and convenient form of combined therapy for ordinary acute upper respiratory infections.

56 Oak Trail Road, Hillsdale, N. J.

Emotional First Aid

In civil disasters such as floods, fires or tornadoes, there may develop varying degrees of panic. Just as first-aid is needed for physically injured victims, so some sort of emergency care is needed for the emotionally traumatized civilian. In this connection, the American Psychiatric Association has developed a practical, down-to-earth brochure called *Psychological First Aid in Community Disasters*. This 32-page pamphlet is available at 35 cents from the American Psychiatric Association, 1785 Massachusetts Avenue, N. W., Washington 6, D. C. (Lower rates for bulk purchase). Here are some quotes from this booklet:

"Unlike ordinary life, a disaster engenders more urgent jobs than there are people to do them. Opportunities to regain self respect and self-confidence are correspondingly greater. Psychological first aid can help many emotionally disturbed victims to take advantage of these opportunities and thereby get back into their stride.

"Here are the major kinds of emotional reactions and ways to deal with them:

"1. *Normal*: Most people show some signs of disturbance which are only natural. A word of encouragement in passing is worth while.

"2. *Individual panic*: Some lose control and rush pointlessly about. A few such persons may set off dangerous mass panic. Gentle firmness should be tried first, then firm but

not brutal physical restraint. There is a false but widespread belief that a casualty in panic can be jolted out of his confusion by slapping him in the face, by dousing him with cold water, or by other forms of abuse.

"3. *Depressed*: Some persons seem to be numbed, to have lost contact with the world. A few minutes talking with them, showing a real personal interest, and suggesting simple tasks to bring them back to reality will help.

"4. *Overly active*: The man who suddenly 'takes over,' issues orders, and rushes from job to job without organization can hamper those who are more reliable. Giving this man a heavy job to work off physical energy, and getting him under proper supervision will help calm him.

"5. *Bodily reactions*: An emotionally upset person unconsciously may convert his great anxiety into a strong belief that some part of his body has ceased to function. He must be treated with consideration for his disability, made to feel you are interested and given small jobs so he can regain composure gradually while awaiting medical help.

"Medical care always should be sought for serious emotional casualties, but the goal of first aid is to control panic, restore moderately disabled persons to reasonably good function in a short time or to make the more serious casualties as comfortable as possible until more complete care can be arranged for them."

HENRY A. BRODKIN, M.D.†

Newark

Cortisone in the Rehabilitation of the Arthritic Patient*

Cortisone as an adjunct in the rehabilitation of arthritic patients proved valuable in enabling previously disabled patients to return to productive employment.

A PHYSICALLY disabled citizen of New Jersey may be made fit for employment through services provided by the New Jersey Rehabilitation Commission. New Jersey was one of the first states in the country to enact a law for rehabilitating the physically handicapped. Enacted in 1919, this law created the Rehabilitation Commission to provide rehabilitation services to those having an employment handicap who can be restored to remunerative employment within a reasonable period of time.

It is the major objective of the Rehabilitation Commission to restore or improve the working ability of disabled persons through a program of vocational rehabilitation and physical restoration. The federal Office of Vocational Rehabilitation financially assists similar programs in each state. Both the state and the federal government benefit when a client is completely rehabilitated. Over a period of many years' gainful employment, he returns to the federal government, in income taxes alone, many times the cost of rehabilitation service.

The New Jersey Rehabilitation Commission provides physical restoration, counseling, training, and placement for clients with obvious and hidden types of disability; for example, amputees, spastics, cardiacs, the tuberculous, the deaf. Services of physical restoration are provided by the Commission in accordance with the economic need of the individual. Cases

are not closed until there is definite proof that a client is either unfeasible for rehabilitation, or that he has been placed and functioning satisfactorily at a job.

REHABILITATION service is not as widely used as it should be because (a) the medical profession as a whole is not sufficiently aware of the Commission's services, and (b) the state's social agencies are not sufficiently coordinated to work effectively through the Rehabilitation Commission.

It is good business for the state to rehabilitate its handicapped and to employ them in all fields of private and public industry. Economic and social gains accrue to all concerned — to client, community, the state, and the federal government. According to the 1951 *Annual Report* of the New Jersey Rehabilitation Commission, 1,305 disabled citizens were placed in remunerative employment by the Commission in that year. Payroll deductions for income tax purposes for 1,143 of those rehabilitated amounted to \$256,334; 162 persons were exempt because of dependents.

During recent years, the New Jersey Rehabilitation Commission has been paying for three months' (10.0 grams) treatment with

*From a New Jersey Rehabilitation Commission Study.

†Medical Consultant, New Jersey Rehabilitation Commission.

cortisone in rheumatoid arthritis. The Commission apparently is the first public agency to include cortisone as part of its rehabilitation program.

The Commission assumed the cost of cortisone therapy only if a physician recommended the treatment. There were certain other considerations for eligibility:

1) There had to be an assurance that subsequent therapy would be paid for by the client himself, relatives, a community agency, an interested hospital, or other resource;

2) There had to be an expectation — based on the Commission's experience and on the individual's potentials—that the therapy would make him employable.

It was hoped that in some of the cases, the restored income of the client would enable him to pay for his own cortisone when continued treatment was necessary.

THE Commission paid for a complete medical examination. An applicant had the privilege of choosing his own physician. Before a decision as to treatment was made, the client's aptitudes and interests were predicted through vocational and psychologic tests. Placement assistance was given. In some cases, the client was aided financially in setting up a small business.

The Commission planned this follow-up study, to determine whether cortisone therapy had proved effective in the long-range program of rehabilitation. The results of this are summarized below.

RESULTS

FROM April 1, 1951 to March 1, 1952, the New Jersey Rehabilitation Commission used cortisone in the rehabilitation of 25 patients with rheumatoid and related arthritides.

TABLE 1.
CORTISONE THERAPY
April 1, 1951—March 1, 1952

Case	Age	Diagnosis	Total Dose (Grams)	Cost
1	26	Rheumatoid—degenerative	10	\$200
2	23	Rheumatoid—bed-ridden	10	200
3	49	Rheumatoid—all extremities	10	200
4	33	Rheumatoid—left knee, both ankle joints	3	60
5	25	Marie Struempell—hips; hip flexion contracture, left	10	200
6	34	Rheumatic heart disease	—	—
7	32	Rheumatoid—chronic, progressive	10	240
8	47	Rheumatoid—entire body	10	240
9	32	Marie Struempell—spine and hips	10	240
10	25	Marie Struempell—hips; hip flexion contracture, left	10	240
11	60	Rheumatoid—entire body	10	200
12	63	Rheumatoid—all joints	13	345
13	58	Rheumatoid—all joints	5	120
14	51	Rheumatoid—all joints	15	300
15	35	Rheumatoid—all joints	10	200
16	46	Rheumatoid—hands, knees	10	200
17	24	Rheumatoid—all joints	10	200
18	37	Marie Struempell—shoulders, back	—	—
19	28	Rheumatoid—back, ankles	10	200
20	23	Chronic pulmonary granulomatosis	5	100
21	31	Rheumatoid—hips, spine	8	176
22	34	Marie Struempell—fusion cervical dorsal spine	10	200
23	39	Marie Struempell—hips and hip joints	10	240
24	33	Marie Struempell—deformity of thoracic cage	11	308
25	27	Rheumatoid—spinal, elbows, wrists hips, knees, ankles	10	200
TOTALS			220	\$4,809

Table 1 summarizes the ages, diagnoses, the dosage made available, and the cost of the drug in this group. The average cost for these 25 patients was \$200 per client.

Up to March 1952 there were 7 cases still under treatment, with effectiveness undecided; good results were attained in 10; there were questionable results in 8. Eight clients were earning salaries ranging from \$25 to \$80 per week.

Questionnaire Follow-up. In June 1953, over a year later, 22 of these 25 patients completed questionnaires aimed at evaluating the more long-term aspects of the program. The patients were asked the following questions:

1. Are you now employed? Full time? Part time? Homemaker? Unemployed?
2. Have cortisone treatments been continued after the supply was stopped by the Commission? If treatments have been continued, what is your present dosage?
3. How long have you been under treatment?
4. Is your illness troubling you? To what extent?
5. What kind of work are you doing?
6. Is the job you are filling now the same job you held before your illness?
7. Do you have any physical limitations as far as the actual duties of your job are concerned?
8. Is it your feeling that the use of cortisone has materially benefited you?

ANSWERS to the questionnaire revealed:

TABLE 2. PRESENT STATUS OF WORK	
	No. of Cases
Full time	9
Part time	2
Housewife	4
Unemployed	7
TOTAL	22

Of the 22 who answered the questionnaire, 14 had discontinued the treatments, while 8 were continuing cortisone beyond that supplied by the Commission. Of these, four were taking 50 mg. daily, two were taking 75 mg., and two were taking 100 mg.

To the question, "Is your illness troubling you, and to what extent?" the answers were those summarized in Table 3.

TABLE 3.
DEGREE OF SYMPTOMS

	No. of Cases
None	2
Slight	4
Moderate	12
Severe	3
No answer	1
TOTAL	22

According to their present employment or unemployment, 2 patients have been partly rehabilitated, 15 have been well rehabilitated, while 5 have not been rehabilitated.

OF THESE 15 clients with good rehabilitation, 3 returned to their former jobs, while 12 were re-trained for some type of new employment. Table 3 indicates that most of the subjects still had moderate symptoms. However, most of these were able to return to industry for productive work. Twelve reported they could work despite residual physical limitations.

In the questionnaire, the clients were asked to express their opinions as to whether cortisone had benefited them. Answers ranged from a few words to a letter. Of the 22 respondents, 12 answered "yes," 3 answered "no," 4 had a positive tone, and 3 showed a negative tone.

The following case history refers to No. 9 in Table 1:

A 32-year old man suffered from rheumatoid arthritis with spondylitis (Marie-Struempell disease) for more than 6 years. He uses a cane.

Previous to his application to the Commission, he had received cortisone for one year (dosage not stated), which had lessened his disability somewhat and afforded him great relief from pain. Cortisone was resumed (total dosage, 10 grams during 3 months), to which he responded well. He continued on cortisone maintenance therapy.

This unmarried man had been living with his widowed mother who worked for a small salary. Because of his illness, he had not been able to hold any job for long during the last 6 years. At the time cortisone therapy was resumed, the Commission helped him get employment as a clerk.

He did well at this job, with prospects of continuing employment. Since psychologic tests had revealed good finger dexterity and since he responded well to cortisone, he was able to pursue a course in drafting while employed. In his physician's words, "Cortisone in this case has made an employable person of a young man who would otherwise be bedridden."

His answers to the questionnaire of June 1953 show that he is now employed part time. He has continued cortisone treatments at his own expense after the supply was stopped by the Commission. His present dosage is 50 mg. daily. The extent of his present illness is moderate discomfort. He now works in a tailor shop doing sewing, pressing and cutting. At his job he uses a cane and cannot sit long; he feels that cortisone has enabled him to work and feel better.

SUMMARY AND CONCLUSION

1. The New Jersey Rehabilitation Commission apparently is the first agency of its kind to include cortisone therapy as another one of its rehabilitation services.

2. During the year ending March 1, 1952, cortisone was made available to 25 clients. Over a year later (in June 1953), 22 of these 25 clients filled out and returned a questionnaire designed to aid in evaluating the long-term effects of the program. Returns indicate that cortisone in conjunction with other rehabilitation services has enabled 15 clients to become gainfully employed.

3. Although cortisone has contributed to

their improvement, the drug is only one of many adjunctive measures utilized in rehabilitation services. Cortisone, by its ability to afford symptomatic relief, made them more responsive to other measures such as job retraining and psychologic supportive therapy — so important in the rehabilitative process.

4. A significant proportion of the clients were able to purchase their own cortisone beyond that supplied by the Commission and to become independent of state aid. The expenditure of state funds can be justified by the restoration of rehabilitated, employed clients to self-reliant, useful citizens.

5. For the period 1951-1952 good results with cortisone therapy were attained in 10 cases. Over a year later, according to the follow-up study, the number had increased to 15.

6. The amount of rehabilitation that was acquired was maintained, if not even further advanced.

7. Many clients were able to take cortisone for maintenance without developing refractoriness or complications of therapy.

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Speaker—DR. HENRY W. BROSIN, Director of Western Psychiatric Institute of Pennsylvania and Professor of Psychiatry, University of Pittsburgh.

Topic—PROBLEMS OF EATING.

ALL PROFESSIONAL PERSONNEL WELCOME

MAUS W. STEARNS, M.D.

New York, N. Y.

Prophylaxis of Bowel Cancer*

The incidence of cancer of the colon and rectum could be reduced 50 per cent if all mucosal polyps in that area were detected and eliminated. Sigmoidoscopy detects more of these polyps than does the x-ray. A combined roentgenologic, clinical and sigmoidoscopic study would lead to the detection of nearly all such polyps.

CANCER of the large bowel is responsible for about 35,000 deaths in the United States each year. Cancer of the colon and rectum represent about 15 per cent of all cancer. Each year the number of persons in the "cancer-age" group increases. Thus, unless a more effective program is developed, the number of deaths due to this cancer is going to increase every year.

There are two ways of decreasing the number of deaths due to cancer of any portion of the body: (1) decrease the incidence of cancer in that site; (2) increase the curability of established cancer. The latter is the object of much current research and will not here be reviewed. Instead I will focus on the sober fact that *today it is completely practical to decrease substantially the incidence of bowel cancer.*

This begins with simple sigmoidoscopy to detect the premalignant lesion: the polyp. Once discovered, it can be eradicated before malignant change occurs. I use the word "polyp" to include only a true glandular neoplasm arising from the mucosa of the bowel. Hypertrophied anal papillae, lymphoid follicles, carcinoids, and other polypoid tumors are *not* polyps.

THERE is overwhelming evidence that these polyps *do* become malignant. The literature on

this is extensive, unequivocal, and need not here be reviewed. The relationship between polyp and carcinoma is postulated from, among others, these four facts:

(1) All stages between benign adenoma and highly malignant carcinomas can be seen on histologic study of polyps.

(2) Throughout the large bowel, the distribution of polyps is almost identical with the distribution pattern of carcinomas.

(3) From 20 to 35 per cent of all segments of bowel removed for carcinoma will show associated polyps.

(4) Meticulous histologic study of bowel cancer will show the remnants of "benign" adenoma in about 15 per cent.

There is no direct statistical datum indicating how many polyps become cancer. In a study of 265 colonic polyps, about 15 per cent showed cytologic changes of carcinoma which represents a minimum incidence of transformation. Presumably others would become malignant if left to grow in their host sufficient time. Undoubtedly there are polyps which would never become malignant. But there is no present way of separating these from those which will become malignant. Until such differentiation becomes possible, these tumors must all be regarded as potentially malignant. Small biopsy bites of these tumors *cannot* be relied

*Read, by invitation, Annual Meeting, The Medical Society of New Jersey, May 19, 1954.

on. The bite may not be representative of the remainder of the tumor.

What proportion of bowel cancer starts in polyps? Several authors have found remnants of benign polyp in about 15 per cent of all bowel carcinomas. Helwig, in an autopsy study, reported twelve early carcinomas, ten of which were found in polyps. Only two arose directly from the mucosa. Westhues stated that 60 per cent of all cases of rectal cancer could be proved or almost certainly presumed to be of polyp origin. Certainly not all bowel cancer starts in polyps. I have seen a cancer as small as 5 millimeters arising directly from the mucous membrane with no evidence of polyp. These very tiny cancers are rarely seen in routine sigmoidoscopy. Polyps with cancer in them are commonly found. I am convinced that at least 50 per cent of all bowel carcinoma starts in polyps. By detecting and eradicating all polyps we would reduce the incidence of bowel cancer by at least 50 per cent. Our efforts to cure established cancer would, by comparison, be reduced to secondary importance. The opportunity for practicing true cancer prophylaxis in this area is unequalled in any other part of the body.

THE prophylaxis of bowel cancer, thus starts with the detection of polyps. This is accomplished for the most part simply, quickly, and inexpensively by sigmoidoscopy. The sigmoidoscope should be in the equipment of every physician who does physical examinations. No doctor would consider himself a competent examiner if he never used a stethoscope or a speculum. So the sigmoidoscope should be part of the every day equipment of the conscientious medical examiner.

To be sure, not every doctor can handle an esophagoscope or a bronchoscope. But sigmoidoscopy is comparable to visualization of the cervix rather than to esophagoscopy. It must not be the monopoly of any specialist, but rather the common skill of all competent medical examiners. There are few hazards connected with its use if it is preceded by a digital examination and if the instrument is passed gently under direct vision into a clean

bowel. Familiarity with what is seen is gained rapidly with use.

Medical school authorities are beginning to recognize the importance of teaching students the use of this instrument. It is time that hospital authorities responsible for intern and resident training recognize the need for providing instruction and practice in sigmoidoscopy. This responsibility includes the provision of facilities for sigmoidoscopy such as an examining room in which are available, a table, an all-purpose 8- to 10-inch sigmoidoscope, and if possible suction apparatus. Supervision should be provided. Hospital authorities responsible for surgical standards of practice should insist on sigmoidoscopy on all patients prior to anal or rectal surgery except under unusual circumstances. While supervision and instruction are desirable, if it is readily available, the physician who simply gets himself a sigmoidoscope and puts it to use will soon become acquainted with what he is looking at.

There is one extremely important finding usually missed by those beginning to work with the sigmoidoscope. This is the presence of flecks of blood or blood-stained mucus. If this is noted above the mid-rectum, on repeated examinations after preparation of the patient with castor oil, it is practically pathognomonic of a polyp or other tumor higher in the bowel. If this is seen on repeated examination in the absence of an obvious explanation such as ulcerative colitis, the possibility of exploratory laparotomy with coloscopy should be given serious consideration.

It is not practical for every practitioner to sigmoidoscope every patient who enters his office. But there are certain criteria which should routinely lead to sigmoidoscopy. They are as follows. Do sigmoidoscopy on:

1. Any patient with bowel or anal symptoms.
2. Any patient on whom anal surgery is contemplated.
3. Any patient who wants a "complete check-up."
4. Any patient who comes for a cancer detection study.
5. Any patient with a family history of gastrointestinal malignancy.
6. Any patient with a family history of rectal or sigmoidal polyps.

7. Any patient over the age of 45. It is in the fourth decade that the incidence of polyps begins to rise; and the incidence of cancer has its most dramatic upswing in the fifth decade.

What is the proper interval between sigmoidoscopic examination of patients who are asymptomatic, in whom neither polyp nor cancer has been found and in whom there is no familial history of gastrointestinal cancer? This could be from two to three years and still be within reasonably safe limits.

THE limitation of sigmoidoscopy in the detection of colon and rectal polyps lies in the fact that only the distal 8 to 10 inches of the bowel can be seen. The presence of blood flecks or bloody mucus will often point to a tumor in the bowel beyond the range of the scope. Thus the examination must be supplemented by radiographic study of the colon. There is controversy among radiologists as to the most satisfactory method of demonstrating small colonic polyps. Some prefer air-contrast methods. Others use dilute suspensions of barium sulfate with moderate voltage radiations; while others use normal opacity barium suspension with fluoroscopy at moderate voltage and high voltage for films. Our radiologic colleagues who are particularly interested in the detection of colonic polyps prefer air-contrast studies after evacuation of barium.

Radiologic methods — even the best of them are subject to certain limitations. The most frequent abuse is this: *barium x-ray studies are not reliable for the diagnosis of rectal lesions*. This is the area for the proctoscope, not the roentgen tube. Next, 4 or 5 millimeter polyps can *occasionally* be demonstrated by x-ray. They have to be at least 10 millimeters in size to be visualized with *regularity*. Finally, unless the colon is free of feces the examination is of no value in a program for detecting small polyps. As a corollary to this, if a polyp is demonstrated by x-ray, its presence should always be confirmed by a repeat examination on a subsequent day. A small fecal particle may be mistaken for a polyp.

It is desirable in presenting a practical program to consider the economic barriers that

might bar its widespread use. Thus, in the detection of colonic polyps, radiographic studies are necessary. It would be unrealistic to expect that every patient over thirty-five years of age should have a barium enema study at a cost of from \$15 to \$40. We have the experience of several detection clinics to guide us in this. At the Strang Cancer Detection Clinic, we have now done over 29,000 proctosigmoidoscopies. These have been done on *all* patients presenting themselves who have any symptoms referable to their bowel, rectum or anus; all those in whom occult blood is found; and *all* patients over forty-five years of age. We have found on routine examination of all patients over forty-five years of age an incidence of polyps of 8 per cent in males and 5 per cent in females. More applicable to the question of the value of radiographic examination was the fact that 95 per cent of all of the polyps detected by this program were found by sigmoidoscopy alone. An additional number were suspected by the sigmoidoscopic findings and confirmed by x-ray studies. Only about 2 per cent were found by radiographic studies alone. From this, I feel that practical indications for radiographic examination of the colon should be (1) definite bowel symptoms unexplained by the sigmoidoscopic findings; (2) incomplete sigmoidoscopic examination; (3) the demonstration of a polyp by sigmoidoscopy; (4) the presence of flecks of blood or bloody mucus proximal to the mid-rectum on sigmoidoscopy; (5) unexplained anemia or occult blood in the meat-free stool; (6) the familial history of gastrointestinal cancer; (7) the question by the patient if the doctor is sure that the patient does not have anything wrong above where he can see.

THE distribution of colonic and rectal polyps based on autopsy series indicates that between 30 and 40 per cent are found above the reach of the sigmoidoscope. In clinical detection centers, fewer than 10 per cent of all polyps found are above the reach of the scope. This discrepancy has a very simple explanation: polyps less than one centimeter in size cannot be demonstrated with a high degree of regularity. For

some years now we have been practicing, at the time of laparotomy for colon lesions, direct inspection of the entire mucosa of the bowel with a sigmoidoscope through multiple incisions in the bowel. In this way, we have explored 97 for polyps. Forty-six of these (that is 47 per cent) did show additional polyps. And in those on whom resections for cancer had been done, we found polyps beyond the segment removed, in 54 per cent! These additional polyps can be removed without undue hardship. This would practically eliminate the need for reoperation for a few years. It has been shown repeatedly that manual palpation through the bowel wall at laparotomy without direct visualization is inadequate to detect small polyps. Reliance on manual palpation method in the past explains why many patients, explored for polyps of the colon, have had to be reoperated within six months or a year for subsequent polyps. Small polyps were undetected even though present.

THE eradication of polyps generally is the province of the proctologist or general surgeon interested in colo-rectal surgery. There are definite hazards associated with their treatment which anyone assuming the responsibility for treatment should be prepared to meet. The principal hazards are hemorrhage, either immediate or delayed, and perforation of the bowel.

Generally speaking, polyps visualized through the sigmoidoscope can be treated by local means through the sigmoidoscope. Lesions detected by radiography usually require laparotomy. I prefer the cautery snare method of removing polyps through the sigmoidoscope as the entire tumor can then be submitted to the pathologist for study instead of a small and, frequently, not representative fragment. If laparotomy is necessary the polyp, if pedunculated, can be removed by ligation of

to pedicle at its base through an incision in the colon. If there is induration or other evidence to suggest the possibility of malignant change, resection as for fully malignant cancer should be performed.

Long-term follow-up on any patient who has had polyps of the colon and rectum is absolutely essential. These patients should remain under periodic medical observation for the remainder of their lives.

There is one other condition indicted as premalignant by many authors; that is ulcerative colitis of long duration. While this is an infrequent condition as compared with polyps, the possibility should be borne in mind when following a patient with this disease. It should be a supplementary consideration in the decision as to the need for colectomy.

SUMMARY

1. The detection and eradication of all mucosal polyps would reduce the incidence of cancer of the colon and rectum by over 50 per cent.
2. The detection of polyps is accomplished in over 90 per cent of cases by sigmoidoscopic examination of the rectum and distal sigmoid.
3. The detection by sigmoidoscopy is the responsibility not only of the proctologist and surgeon but also, and primarily, of all physicians who examine patients.
4. Radiographic studies are necessary to detect polyps above the reach of the sigmoidoscope. This is subject to certain mechanical limitation which should be appreciated.
5. Colonoscopy, or direct visualization of the colonic mucosa, is an extremely valuable addition to our available diagnostic methods for the detection of small polyps at the time of laparotomy for either polyp or cancer of the bowel.

SIEGFRIED SALOMON, M.D.

JOHN J. SIBLEY, M.D.

PATRICK J. CASHIN, M.D.

Staten Island, N. Y.

Experience with Hedulin[†] An Effective Oral Anticoagulant*

A brand of phenyl indanedione gives promise of being a useful anticoagulant. Here is a report which reflects the effectiveness of this drug in 21 out of 34 thrombo-embolic disorders. The preparation is very useful although not ideal, and this paper spells out its disadvantages as well as its merits.

THE value of anticoagulants in the treatment of thrombo-embolic conditions has been firmly established by Wright^{9,10,11} and other leading authorities. In the search for an ideal prothrombopenic agent, the indanediones have been investigated extensively.¹ Clinical studies have indicated the efficacy of phenylindanedione,^{1,2,8} particularly with reference to its speed of action, ease of maintenance, and safety.^{2,3,5} The present study is an effort to determine whether the previously reported good results could be reduplicated in a suburban hospital, among an ethnologic cross-sectional community population. The product used was a phenyl indanedione, Hedulin®.

Thirty-four unselected patients were studied in this consecutive series. All patients requiring anticoagulant therapy during the period of observation were included. A control series was not run concurrently. Table 1 lists the major indications for treatment and the associated case distribution. Myocardial infarction was our primary indication for prophylactic institution of therapeutic hypoprothrombinemia.

This accounted for 48 per cent of the series. The diagnoses were confirmed by clinical and electrocardiographic evidence. Patients demonstrating embolic phenomena (central and peripheral) formed the second largest group, totalling 24 per cent of the series, including 5 pulmonary, 1 renal, and 2 peripheral embolizations. Thrombophlebitis accounted for 15 per cent. The remaining four cases, whose treatment was based upon a working diagnosis of myocardial infarction, were later demonstrated to have transient coronary insufficiency.

FOLLOWING the establishment of the diagnosis and of a "baseline" prothrombin level, anticoagulant therapy was promptly begun.

TABLE 1. INDICATIONS FOR THERAPY

Diagnosis	Cases	%
Coronary Thrombosis	16	48
Suspected Coronary Thrombosis (Coronary Insufficiency)	4	12
Thrombophlebitis	6	18
Pulmonary Infarction	5	15
Renal Embolus	1	3
Peripheral Embolus	2	6
	34	

*From Department of Medicine, St. Vincent's Hospital, Staten Island, New York.

†Hedulin is 2-phenyl-1, 3-indanedione, generously provided by Walker Laboratories, Incorporated, Mt. Vernon, N. Y.

Throughout the study, active control of therapy was under the direction of one of us (P.J.C.). Daily prothrombin time determinations were performed using the one-stage Quick method. Prothrombin activity was expressed in seconds. The normal range is from 12 to 17 seconds. The optimum therapeutic range, as established by Wright¹¹ is 25 to 39 seconds, or 2 to 2½ times the control prothrombin time. This range was our goal.

DOSES

INITIAL dose of Hedulin® was 100 to 400 mgms. in divided doses, depending on the patient's habitus, with caution exhibited. Three patients received 100 mgms., eight 200 mgms. Twenty-two patients received 300 mgms., and one received 400 mgms. The subsequent dose was gauged by the effect of each preceding dose upon the prothrombin time. Total dosage required to achieve a therapeutic level varied from 250 to 800 mgms. (Table 2), distributed over a period of time from the onset of therapy ranging from 24 hours to seven days (Table 3). Mean total dosage was 500 mgms., distributed over a mean time of 48 hours. Daily maintenance requirements were from 50 to 200 mgms. The average was 100 mgms., daily (Table 4), based on 30 cases. Of the remaining four patients, one demonstrated resistance to the drug. Treatment of one was discontinued because of hematuria. Two patients died, one of his original disease (acute myocardial infarction), the other of gastro-intestinal bleeding secondary to the therapy (see below, under Complications).

THE effective initial and maintenance doses correlate closely with those suggested by Blaustein *et al.*,² and corroborated by other clinical studies.^{5,6} The higher dosage requirement reported by Shapiro⁷ and Fisher *et al.*,⁸ namely 900 mgms. and 500 mgms. initial doses, and 300 mgms. and 150 mgms. maintenance, respectively, were not found necessary in this series. The time required to establish therapeutic prothrombin time levels was somewhat

longer, on the average, than previously determined.^{2,5}

The superiority of divided doses of medication over single daily doses, as demonstrated by O'Connor,⁵ was clinically reaffirmed.

The relative ease of maintenance is demonstrated graphically in Figure 1. For prolonged ambulatory therapy, Hedulin® appeared very useful. One patient, for example, was maintained at remarkably constant prothrombin levels of 30 seconds (tested once weekly) for seven months on 75 mgms. daily. No cumulative effect was noted. The level returned promptly to normal after the drug was discontinued because the patient had to have a tooth extracted.

RESISTANCE

RESISTANCE to oral anticoagulants noted in earlier studies^{2,3} was demonstrated in only one case. The patient was believed to

TABLE 2. DOSAGES TO ACHIEVE THERAPEUTIC LEVELS

Dosages	Cases
Under 300	1
300-399	2
400-499	8
500-599	12
600-699	5
700-799	1
Over 800	2

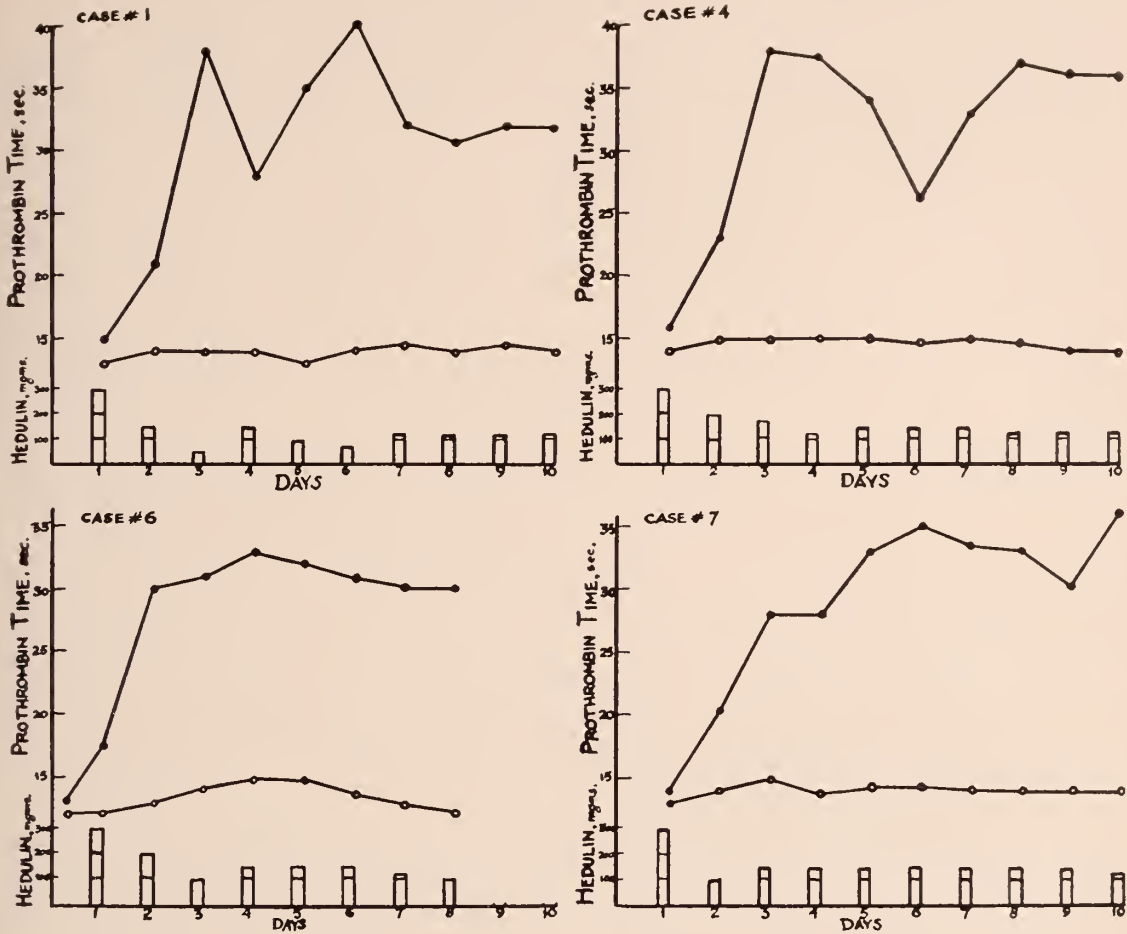
TABLE 3. TIME TO ACHIEVE THERAPEUTIC LEVELS

Time	Cases
24 Hours	3
48 Hours	22
72 Hours	6
7 Days	1
Resistant	1

TABLE 4. DAILY MAINTENANCE DOSAGES

Dosages	Cases
50 mgms	1
75 mgms	5
100 mgms	10
125 mgms	6
150 mgms	5
175 mgms	1
200 mgms	2
Discontinued	1
Died	2
Resistant	1

Figure 1.



have an embolic occlusion of the right popliteal artery, probably arising from an arteriosclerotic plaque of the abdominal aorta. No hypoprothrombin effect was noted in the face of daily doses of up to 300 mgms., divided, over a 15 day period. Remarkable improvement in the patient's condition (which made us doubt the original diagnosis), interdicted further attempts at achieving therapeutic levels through the use of other drugs, specifically those of the coumarin family. From an academic point of view only, this latter was unfortunate, because it was impossible to demonstrate the nonspecificity of this resistance. Blaustein *et al*² observed a resistance to oral anticoagulants in general. Our one case in 34 corresponds well to the one case per 27 in the series of 400 cases reported by Blaustein *et al*.² Relative resistance in three cases was indicated in the present study by daily re-

quirements of over 150 mgms. In these, however, adequate prothrombopenia was readily maintained at the higher dosage levels.

RECOVERY

IN 34 patients, Hedulin® was discontinued. The reasons for the discontinuation were:

Improvement	18
Lost to follow-up	8
Discharged on ambulant therapy	4
Resistant to therapy	1
Received vitamin K ₁ oxide	1
Died	2
	34

The recovery time in the 18 improved cases varied from 24 to 96 hours as reflected in Table 5. Most patients (55 per cent) recovered within 48 hours. This relatively rapid re-

covery rate is particularly desirable in an anticoagulant should the necessity for surgery arise. No such urgent need, however, arose in this series. Vitamin K₁ oxide was employed in one patient in whom hematuria developed coincident with a prothrombin time of 86 seconds. Forty-eight hours after 200 mgms. of Vitamin K₁ oxide prothrombin levels were again normal.

TABLE 5. RECOVERY TIME

Time	Cases	%
24 Hours	2	11
48 Hours	8	44
72 Hours	5	28
96 Hours	3	17

COMPLICATIONS

Two episodes of gross bleeding occurred during therapy, one fatal. This patient had been under anticoagulant therapy for four days because of acute coronary thrombosis, when suddenly, without premonitory signs, he succumbed. His past history was noncontributory except with respect to his coronary artery disease. At the time of death, prothrombin time was 52 seconds. Autopsy revealed an acute bleeding duodenal ulcer, with considerable intraluminal blood. Perhaps closer surveillance for excretory occult blood could have prevented this untoward result. Accordingly, fecal guaiac tests and microscopic urine analyses were performed during the course of treatment. In two patients, occult gastro-intestinal bleeding was discovered. Three others demonstrated microscopic hematuria. All bleeding of minor nature occurred within accepted levels of prothrombin activity. No alteration of therapy was deemed essential in these five, but caution was maintained.

Gross hematuria in one patient occurred on the fifth day of therapy with a prothrombin level of 86 seconds. The level was returned to normal within 48 hours after two daily intravenous doses of 100 mgms. of Vitamin K₁ oxide, accompanied by the prompt cessation of urinary tract bleeding.

The frequency and severity of our hemorrhagic complications is in contradiction to the

observations of Blaustein *et al.*,² who said that bleeding occurred rather infrequently, and that the bleeding was "mild" and rapidly responsive to Vitamin K₁ oxide. No embolic complications occurred during the course of therapy.

No toxic side-effects were noted in this series. The orange-brown urinary discoloration due to a phenindione derivative in alkaline urine, described by Fisher *et al.*,³ was observed in two patients shortly after the therapy was begun. Urinalysis in these cases was unrevealing.

Prothrombin time went out of control, (*i.e.* well above the established safe range of 25 to 39 seconds), in six cases. One ended fatally (acute hemorrhage from duodenal ulcer); one was controlled with Vitamin K₁ oxide; the remaining returned to normal promptly after the withdrawal of the medication. Subsequent therapy, where it was deemed necessary, was reinstituted without difficulty.

CONCLUSION

THAT Hedulin® is still not the ultimate in anticoagulants is apparent. It does possess specific advantages over Dicumarol® and other coumarin derivatives, particularly in speed of action and recovery. Moreover, the lack of cumulative action is advantageous. Although hemorrhage during anticoagulant therapy is an anticipated risk, it would appear that this risk is unnecessarily augmented by the use of a drug which may so readily sky-rocket the prothrombin levels into the "danger zone." This disadvantage is reduced somewhat however, by the relative ease with which levels may be returned to normal, by withdrawing the drug and/or administering Vitamin K or K₁ oxide. Ease of maintenance has not been verified for all patients. Most, indeed, were readily maintained within the therapeutic anticoagulant range. The six who went out of control (including the two resulting bleeding episodes, as well as the patient who was completely resistant to the drug) stand apart. In general, Hedulin® may be said to allow for easy control within

therapeutic levels, but the idiosyncrasies among patients must constantly be kept in mind. Because of this, especially with reference to hemorrhage, pathologic bleeding must be watched for. Thus alerted, routine observations of urinary sediment and determinations for occult blood in the feces will permit early detection of potentially dangerous hemorrhagic complications.

SUMMARY

1. Thirty-four cases of thromboembolic disorders were treated with Hedulin®, which is 2-phenyl-1, 3-indanedione.
2. Hedulin® proved effective as an antico-

agulant in 21 cases, demonstrating rapid onset of action, relative ease of maintenance, and prompt recovery.

3. Seven patients demonstrated bleeding phenomena, five inconsequential, one of gross hematuria, and one fatal bleeding duodenal ulcer.

4. Prothrombin times of six patients went out of control. All, except the one which terminated fatally, were brought promptly and easily back to therapeutic or normal levels.

5. Complete resistance to Hedulin® was observed in one patient.

6. Early detection of bleeding phenomena is stressed. Routine microscopic urinalyses and fecal guaiac determinations are recommended.

117 Hart Boulevard

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EUGENE J. LUIPPOLD, M.D.

Boonton

Prevention of Penicillin Reactions*

Dr. Luippold conspicuously reduced the incidence of penicillin side-reactions by adding chlorprophenpyridamine maleate to each injection of penicillin.

PENICILLIN is the most widely used antibiotic in the world. This is due to its low cost, its availability in numerous forms, its synergism with other antibiotics, its wide spectrum in the more common illnesses and to our familiarity with it as a result of thorough study over a ten-year period. Its widespread use is a mixed blessing. Dosage has been increased from the original 20,000 units every three hours to the now frequently used million-unit range. Along with this inflation of dosage, there have developed increasing reports of major toxic reactions. These reactions have increased from 2 per cent in the earlier reports all the way to 8 or 10 per cent today.¹ They include reactions of all types, from contact dermatitis, Arthus reactions, exfoliative dermatitis, and urticaria, to angioneurotic edema of the larynx and anaphylactic death. Since Waldbott reported the first death in 1949, increasing numbers of such cases have been reported, with at least 15 in the past eighteen months.² There is a probability of a great many more unreported cases. Almost all serious anaphylactoid cases have been characterized by an immediate "taste" of penicillin in the mouth, a sense of constriction of the chest, cyanosis, and circulatory collapse. Steinhardt³ reported that penicillin in the past five years was the cause of 15 per cent of all cases of urticaria, in contrast with only 3 per cent in the preceding five years.

Perhaps one of the greatest causes of trouble is the assumption that, because a patient says,

"I've had penicillin before," he will not now show a reaction to it. This is the *opposite* of basic allergic principles. Anaphylactic reactions occur *only* in those who have had previous sensitizing exposures. It can occur even though the penicillin was apparently well tolerated before.⁴ Ointments and troches are especially prone to cause the development of sensitivity. The use of ointment particularly has been almost discontinued for this reason. Systemic reactions have been seen after parenteral administration in cases where the sensitization has been from topical use only.

The so-called hypo-allergic penicillins are not the answer. There is too high a degree of cross-sensitivity⁵ between penicillin "G" and penicillin "O": Benzathacil (Bicillin®) and penethamate (Neo-Penil®) have been equally guilty of causing side reactions.

Intradermal, scratch and patch tests have been found helpful in picking out some of the sensitive patients. They are time-consuming and inaccurate. Severe reactions have been

*Read at the Annual Meeting of The Medical Society of New Jersey, May 19, 1954.

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reported in patients with "negative" tests. They are of no help in predetermining the delayed urticarial reaction. For all these reasons, such testing is now little used. The "inhalation test" with vital capacity readings may be more accurate. But it is even more time-consuming and may of itself, be dangerous to the sensitized patient.

CAREFUL history of any possible preceding evidence of penicillin sensitivity is a most important precaution. Five of the sixteen anaphylactic deaths reported by Collins-Williams⁶ had had symptoms of some sort, such as mild itching, or a sense of constriction in the chest, or a severe local reaction at the site of the injection. Four of the six cases of severe reaction reported by Mayer⁷ gave a history of penicillin sensitivity symptoms which had been ignored. Questioning on this point should be a routine, preceding *every* injection of penicillin, *even those given to a single patient in a consecutive series.*

Since chlorphenpyridamine maleate† (100 milligrams per cubic centimeter) became available, I have used it routinely in all penicillin injections. Its toxicity is very low.¹¹ The average therapeutic dose (oral) is 4 milligrams. Yet even with 10 milligram intramuscular doses, no toxic effects (except those below mentioned) have been reported. Animal toxicity is also very low, 2 mg. per kilogram having been given over a period of months without abnormalities in the vital organs of the rat and dog. The cellular elements and hemoglobin content of the blood were not altered.

This series now consists of 2500 injections in a group of 1887 consecutive unselected patients, and confirms the earlier reports of Simon,⁸ Jenkins,¹⁰ Sanger,⁹ and others as to the effectiveness of the addition of 0.1 cc. of this solution, containing 10 mg., to each injection of penicillin. In this series, there were only three cases of penicillin reaction and those were in *known* penicillin-sensitive patients. These reactions included a mild, generalized itching after the third dose in one case. There was no visible evidence of skin rash or ery-

thema, and the itching ceased completely in about two days. In another case similar itching after the first injection of penicillin was reported. This was relatively mild, however, and the patient has subsequently been able to tolerate additional injections, although each is accompanied by itching lasting for several days. A third patient developed moderately severe urticarial lesions which were relieved by oral antihistamines and cortisone in forty-eight hours.

A fourth case is briefly presented to illustrate the effectiveness of the included antihistamine. This is a 56-year old man. The provisional diagnosis was subacute bacterial endocarditis following dental extraction. He was first given 2.4 million units of procaine penicillin daily. Three days later this was increased to 10 million units daily. A generalized maculo-papular rash and itching developed. Skin tests to penicillin were negative. The penicillin was resumed with 10 milligrams. Chlorphenpyridamine maleate† was then added, twice a day to the penicillin injection. The rash and itching swiftly disappeared and the patient continued on 9 million units of penicillin daily for twenty-eight days without difficulty. He was discharged in good condition. In this case, a developing penicillin sensitivity was overcome, and the patient was able to tolerate large doses over a considerable period of time.

THIS series includes successful administration of penicillin in eight other known penicillin sensitive patients. There were *no* cases resembling anaphylactoid type reactions. Many did complain of momentarily increased pain at the time of the injection, but this invariably disappeared within one or two minutes, and there were no reports of delayed pain at the injection site, as many patients had noticed with

†Tradenamed as Chlor-Trimeton Maleate® (NNR), by the Schering Corporation.

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previous penicillin injections. Slight to moderate drowsiness was reported with considerable frequency.

CONCLUSION

THE increasing numbers of anaphylactoid deaths, as well as the more numerous milder reactions of penicillin sensitivity, have stimulated the search for a preventive agent. A series of cases contrasting an incidence of 3

in 2500 or 0.12 per cent is compared to the recently reported incidence of 8 to 10 per cent. This result was obtained by the addition of 10 milligrams of chlorprophenpyridamine maleate† solution to each injection of penicillin. The report confirms and supports the earlier work of Sanger,⁹ Simon⁸ and others as to the effectiveness of this procedure. A plea is made for the wider use of this safety measure as a routine in hospital and private office.

West Main Street

Black Widow Spider Bites*

Arachnidism is caused by the bite of the black widow spider (*latrodectus mactans*). This insect has been reported in every state in the country except Vermont and is particularly prevalent in the southern states, the Ohio valley and the western coastal regions.

The adult female is solely responsible for biting humans. It has a shiny black body composed of a minute head, a somewhat larger thorax and a large oval and globoid abdomen. On the ventral surface is a characteristic hour-glass (T-marking) red spot.

The poison of the female black widow is fifteen times as powerful as that of the rattlesnake. It contains a thick translucent oily lemon yellow colored fluid, acid in reaction, and contains a hemolysin and arachnolysin. It is a toxalbumin and it acts by stimulating the myoneural junctions or acts on the nerves and the nerve endings.

Clinically the patient gives a history of having had a bite or sting which he may have ignored. The initial pain lasts only a few seconds or minutes and then disappears. A few cases show a small erythematous patch at the site of injury; this may persist for as long as twenty-four hours or may disappear completely within a brief period.

The next phase starts from fifteen minutes to two hours after the bite and is characterized by a return of the pain which then spreads along lymphatic drainage channels. The patient, when first seen, groans persistently, is restless and is unable to remain quiet long

enough to be examined properly. There may be generalized cramplike muscular pains but the predominant findings are excruciating and agonizing cramping pains of the abdomen. At this point the abdomen has board-like rigidity but shows no localized tenderness. Nevertheless the pain is so severe that it is said to equal or exceed that of ruptured peptic ulcer, kidney colic, acute appendicitis or coronary occlusion. The muscular pain, unless treated, will eventually involve almost all skeletal muscles, including the abdomen, thighs, leg, feet and occasionally those of the chest, shoulders, back and arms.

Other symptoms of arachnidism occasionally include convulsions, paralysis, urinary retention, shock, delirium, cyanosis, nausea, vomiting, anxiety and cold sweats. The acute symptoms usually subside within six to forty-eight hours. In more severe cases, however, they may continue or recur with progressively decreasing severity for a number of days.

The best and only specific treatment is the anti-venom (antivenin *latrodectus mactans*) which is an immune serum prepared by concentrating and drying the serum of horses which have been hyperimmunized with the venom. The usual dosage is 2.5 cc. of restored serum given deeply in the muscle. An occasional patient requires an additional 2.5 cc. which may be given one to two hours later. It is important that intradermal and conjunctival tests for allergy to horse serum be performed before the antivenin is administered.

In one series of 400 cases there were seventeen deaths. However, generally the prognosis is favorable. Arachnidism usually results in complete recovery without sequelae.

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ALFRED J. MAGEE, M.D.

Jersey City

Retrolental Fibroplasia at a New Jersey Maternity Hospital*

In this pioneer study, a survey is made for the first time of the incidence of retrolental fibroplasia in a New Jersey institution. The incidence approximates 11 per cent of surviving babies who weighed less than 2000 Grams at birth.

THIS is a report of a study of retrolental fibroplasia at the Margaret Hague Maternity Hospital in Jersey City, N. J. The period covered is from January 1, 1950 to September 21, 1953. During this time concepts of the disease have changed considerably. The various types of therapy were tried as they were in fashion—Vitamin E, adrenocorticotrophic hormone and several methods of oxygen administration.

Examination began 30 days after birth and was done usually once a week till discharge from the hospital. After this, follow-up was continued on an out-patient basis.

The pupils were dilated with 10 per cent phenylephrine hydrochloride and 4 per cent homatropine hydrobromide. No speculum was used. The findings are grouped according to the classification of Reese.†

Premature infants under 2000 Grams are included. Only those patients examined at least once were eligible for evaluation. Many babies were examined as much as ten times and as late as two years of age.

During this time, four babies were admitted to the hospital who were born in other hospitals; their birth weight was under 2000 Grams

each. An occasional patient was born at home or on the way to the hospital; they had received prenatal care at the Margaret Hague Maternity Hospital and are included. Since only 4 of our 778 infants included in the study were *not* born at the Margaret Hague Maternity Hospital, the figures presented are a fair cross-section of the population. For this reason, the figures are unusual.

INCIDENCE OF THE DISEASE

OF THE babies born at the Margaret Hague Maternity Hospital during the study 778 were under 2000 Grams at birth. Of this number, 323 died soon after birth. The 455 remaining babies survived. Of these, 299 were studied. It was possible to find 33 of these with the disease. This is an incidence of 11 per cent. The yearly incidence is shown in Table I.

There were 63 Negro baby survivors who were studied. Of these eight had the disease. This is an incidence of 13 per cent.

TABLE I
YEARLY INCIDENCE OF RLF

Year	No. of Patients With RLF	Percentage of Infants Under 2000 Grams
1950	5	10.0%
1951	5	6.2
1952	17	16.3
1953	6	9.4

*From the Margaret Hague Maternity Hospital, Jersey City, N. J.

†Reese, Algernon B. American Journal of Ophthalmology, 36:1333 (October) 1953.

TIME OF ONSET

BECAUSE the babies were first examined when 30 days old, the time of onset can be discussed only in general terms. Sixty days was the maximum time before development of the disease. This was in one infant. The disease most often developed prior to 50 days after birth. In general, complications are less likely if the onset of the disease is late.

DURATION

OF THE babies studied, the shortest period of duration of the acute phase was 4 days and the longest 88 days. The average figure was 37 days. Of these, 18 babies could be evaluated.

CLINICAL FEATURES

SEVENTEEN of the thirty-three babies who showed signs of the disease initially, on follow-up study, showed no sequelae. This is an incidence of 51.5 per cent spontaneous regression.

All grades of severity are represented from complete membrane formation to mild, nearly physiologic variations which are impossible to separate from pathologic changes.

In every case, the disease was bilateral. Usually the amount of involvement was about the same in both eyes. One patient showed complete regression in one eye and marked residuals in the other.

The incidence appears to be greater in the lower weight groups. (See Table II). The baby with the highest birth weight to develop the disease weighed 1680 Grams at birth.

In the group under 1361 Grams (3 lbs.) the incidence was 49 per cent. In the group from 1361 to 2000 Grams the incidence was 2 and one half per cent.

When the disease was noted, the average weight was 1649 Grams. Some infants were without the disease when first seen. There were ten such patients.

The series included 77 twins. Of these, seven developed the disease, an incidence of 11 per

cent. There were also nine triplets (that is, three sets of three). Of these nine, three developed retrolental fibroplasia. If a ratio may be calculated from so small a series, the incidence would be 33 per cent.

Of all premature babies who survived, 53 per cent were female. But of those who developed retrolental fibroplasia, 73 per cent were female. In general, I noted that female infants of low birth weight survived more often than did male infants of the same weight. This may be responsible for some of the apparent skewing in the sex distribution of the disease.

There were skin hemangiomas in 6 per cent of the patients with retrolental fibroplasia. In those without the disease the incidence of hemangiomas was 4 per cent.

PEDIATRIC MANAGEMENT

ALL babies received cows' milk. Feeding was started 12 hours after birth. (Some physicians withhold fluids for 2 or 3 days).

On the eighth day, all infants received vitamins. Early in the study vitamin E was also given.

Transfusions of modified "O" blood were given. The relationship to the incidence of the disease is shown in Table III. Although there might appear to be a greater incidence of retrolental fibroplasia when larger amounts of blood were given, there are other factors to be considered. Infants of low birth weight ordinarily received more blood transfusions. Table II shows that the incidence of retrolental fibro-

TABLE II
INCIDENCE OF RLF AND BIRTH WEIGHT
(Infants under 1680 Grams only)

Weight In Grams	No. of Patients With RLF	Incidence in %
800 - 900	1	100.0
900 - 1000	5	83.4
1000 - 1100	6	66.6
1100 - 1200	6	46.1
1200 - 1300	7	41.2
1300 - 1400	3	27.1
1400 - 1500	1	3.1
1500 - 1600	1	3.1
1600 - 1700	3	6.7

plasia is greater in patients of low birth weight. Table III does not prove conclusively, that the amount of blood given by transfusion is related to the incidence of retrolental fibroplasia.

The incidence of retrolental fibroplasia with relation to oxygen administration is shown in Table IV. There is indication here that prolonged oxygen therapy might be related to the incidence of the disease. It can be seen from Table IV however, that many infants received prolonged oxygen therapy and never developed the disease.

SUMMARY

A SURVEY of retrolental fibroplasia at the Margaret Hague Maternity Hospital is presented. There is suggestive evidence that the incidence of retrolental fibroplasia increases with prolonged oxygen therapy.

ACKNOWLEDGMENT

Benjamin Jaffe, M.D. assisted in the examination of the patients.

TABLE III
THE INCIDENCE OF RLF AND BLOOD
TRANSFUSIONS
(Infants under 1680 Grams)

Given in c.c. Amount of Blood	With RLF No. of Patients	With RLF % of Patients
20 - 40	1	20.0
40 - 60	2	6.9
60 - 80	2	25.0
80 - 100	2	18.2
100 - 120	1	14.3
120 - 140	1	10.0
140 - 160	2	18.2
160 - 180	0	0
180 - 200	3	33.0
200 - 220	3	42.9
220 - 240	5	83.4
240 - 260	4	100.0
260 - 280	1	100.0
280 - 300	1	30.0
300 - 340	1	50.0
340 - 420	2	100.0

TABLE IV
THE INCIDENCE OF RLF IN RELATION TO
OXYGEN ADMINISTRATION
(Infants under 1680 Grams only)

No. of Days in Oxygen	Total No. Of Patients	No. of Patients With RLF	% of Patients With RLF
0 - 4	30	1	3.3
5 - 9	29	0	0
10 - 14	15	4	26.6
15 - 19	17	7	41.2
20 - 24	10	3	30.0
25 - 29	6	1	16.8
30 - 34	6	5	83.4
35 - 39	5	4	80.0
40 - 75	9	9	100.0

Note. If we divide the patients into two groups (a) those who were fewer than 30 days in oxygen, and (b) those who were more, the contrast is apparent.

Days in Oxygen	Patients	RLF Cases	Percentage
0 to 29	107	16	15%
30 to 75	20	17	85%

921 Bergen Avenue

ROY R. SCHUBERT, M.D.

Paterson

The Arthritides in Industry*

No x-ray picture or other simple test infallibly distinguishes the traumatic from the nontraumatic arthritis. Yet the doctor must make the distinction for therapeutic, prognostic and legal reasons. Some tips on recognizing traumatic arthritis are offered in this practical paper.

How often have we all seen in the various courts, two competent medical witnesses offering diametrically opposed opinions about the relation of one of the arthritides to the post-injury syndrome of pain and lost motion? The defendant's medical expert says in effect, "This man's x-rays show arthritis, therefore it probably pre-existed the trauma. If it pre-existed the trauma, then his present symptoms *must* be due to a natural progression of the disease." The plaintiff's (or petitioner's) expert retorts: "But this man had no symptoms prior to his injury, in spite of your contention that an arthritis pre-existed. Therefore, his present complaints *must* be due either to the injuries received or to an exacerbation of the pre-existing lesion." This suggests the adage that every story has three sides: your side, my side, and the truth. It is my intention to try to channel your thinking along the middle road which leads to the truth.

What do we mean by the arthritides? The obvious definition does not permit inclusion of many types of arthritis and associated lesions, and a much broader definition is needed. The definition which I am about to give you comes from The Tenth Rheumatism Review, presented in the Annals of Internal Medicine,

September and October, 1953. They describe it as "— a large group of diseases of the musculo-skeletal system characterized by pain and stiffness of joints, muscles, and related structures. These disorders affect the various articular structures (cartilage, joint, capsule and bone), the connective tissues around joints, and in some instances, the fibrous tissues in a wide variety of organs."

NO CLASSIFICATION of arthritis is entirely satisfactory. One of the recent texts submits the following:

1. Arthritis due to known microbial agents.
2. Arthritis of rheumatic fever.
3. Rheumatoid arthritis.
4. Arthritis due to gout.
5. Degenerative joint disease or osteoarthritis.
6. Arthritis due to direct trauma.
7. Non-articular forms of arthritis.

In addition, there is a miscellaneous group for arthritides not properly or distinctly classified under these seven rubrics.

The first four of these are due to specific causes, and in only rare instances will it be asserted that they are due to trauma. Among this group we have such lesions as the septic joint from staphylococcus or streptococcus infection due to penetrating wounds, tuberculosis, gonorrhea, etc. With a penetrating wound

*Presented to the Passaic County Medico-Legal Seminar, March 24, 1954.

followed by sepsis of the joint, there can be no medical question as to the cause and effect. With tuberculosis or gonorrhea, there can be no traumatic cause and effect relationship, but the patient's attorney may insist that there was an aggravation of a pre-existing lesion. In a tuberculous joint, any trauma can cause an exacerbation. With a gonorrheal arthritis, the relationship of trauma and exacerbation is not quite so clear. The incidence of gonorrheal arthritis has so sharply decreased since the introduction of antibiotics, that this need not give us any concern today. It is primarily with the last four groups in the classification that most of us will become involved in formal hearings and civil suits.

OSTEOARTHRITIS

FREYBERG in 1948 said, "Everyone beyond middle age has some degree of osteoarthritis; only some persons are uncomfortable from it and few are disabled." Osteoarthritis is an affliction of the middle and declining years. It develops so slowly and insidiously, that the person has little cognizance of any joint changes. With increasing age, the functional demands on the joints are less. Minimal limitation of function is unnoticed, and any transient ache or pain occasioned by special effort is attributed to being "out of condition." This type of joint disease often leads to honest and vigorous differences of medical opinion. These patients have adjusted to their limitations unknowingly, and are completely sincere in their claim that they had no pre-traumatic symptoms. The opposing medical expert is also completely honest in his belief that there must have been signs and symptoms pre-dating the trauma. The point which seems to be missed by both sides is that while the roentgenologic changes predated the trauma, the trauma itself produced a temporary exacerbation (primarily by reason of a peri-arthritis inflammatory process), which subsides only very slowly by reason of the slow recuperative powers incident to the age of the patient.

SURVEYS have indicated that the incidence of osteoarthritis is between 13 and 79 per cent.

The ratio varies with ages of the group under study. In a recent study on the value of pre-employment lumbar spine x-rays, one author found an incidence of 26 per cent. This, of course, was on the basis of a pure radiologic survey. You can never convince me that one out of every four employable persons has subjective symptoms of a lumbar spine arthritis. But whether the incidence is up to 79 per cent or as low as 13 per cent, it is self-evident that with the average of the population growing older, osteoarthritis will present an ever increasing social, medical and economic problem in future years.

The cause of osteoarthritis is obscure. It is much more prevalent in males. Perhaps the physical labor required of the male is one factor in its development. Indeed, it is more likely to be found in the manual laborer than in the worker with a sedentary job. In all probability, there are many causes, among which are chronic strain, repeated sub-minimal trauma, and possibly chronic focal infection. (The latter is in considerable disrepute today as a competent etiologic factor.)

The pathology begins with softening and fraying of the articular cartilage, and an alteration of the fibrillar system. Its regular parallel distribution is lost. With this loss of cartilagenous elasticity, erosion occurs, followed by marginal proliferation and osteophyte production. Ultimately, the cartilage is completely replaced by connective tissue, with the ultimate destruction of the joint surface.

The x-ray changes are rather characteristic, with decreased joint spaces due to destruction of the cartilage, increased density of subchondral bone, and the appearance of marginal osteophytes. These may be large enough to touch or, occasionally, to fuse with those from the opposite side of the joint. The roentgen appearance of osteoarthritic changes in a joint, does not *ipso facto* indicate symptoms referable to that joint. We have all seen people who have been carrying out an extremely heavy work load, who for some reason or other came to the x-ray table (perhaps for gall bladder or kidney symptoms), who demonstrated marked osteoarthritic changes, but who had absolutely no subjective symptoms referable thereto. On the other hand, we have all seen patients who presented clinical symptoms of pain, restriction of motion, and crepitation, who, on x-ray, revealed only the most minimal changes.

WE ARE dealing with an age group whose recuperative and regenerative powers are not nearly so active as in the younger group. We

are frequently in contact with the individual who has an axe to grind in the courts. It is frequently impossible, for economic reasons, to decrease the individual's activity to a workload which he can tolerate with comfort. Particularly in compensation cases, these workers would benefit tremendously, both physically and psychologically, by a graduated program of occupational therapy. However, the employer does not want to carry on his payroll an individual who cannot carry his share of the workload. The insurance carrier is unwilling to defray part of this man's wages while such rehabilitation is taking place.

In my opinion, insurance carriers, employers, and unions, are all wrong for insisting, as do the Armed Forces, that an individual is ready for all work or for no work. Compensation insurance carriers, if there is no demonstrable injury attributable to trauma, are prone to brand the individual a malingerer, and to seek a financial settlement of the problem. Employers are unwilling to have a man on the payroll, who, by reason of seniority or other factor, cannot do the job which he has previously been doing. Unions, on the other hand, through their insistence of seniority benefits, and through the well meaning vigor of unknowing shop stewards, insist that the man stay home until he is well able to carry on his previous job.

ARTHRITIS DUE TO TRAUMA

A FRACTURE which involves a joint surface, no matter how minor or undisplaced, will ultimately produce an irregularity of that surface. Even with no displacement, and normal replacement with fibrocartilage, a scar remains which mars the perfection of the highly polished articular surface. (I use the term "highly polished" in its mechanical, rather than medical, sense.) More severe displacement produces more irregularity and more likelihood of permanent damage to the joint. In many instances, the irregularity which results may actually be responsible for a rapid mechanical erosion of the opposite, uninvolved surface. A common example of a true traumatic arthritis is the one following depressed fractures of the tibial

plateau, and the subastragalar arthritis following fractures of the os calcis. In the latter, traumatic arthritis is considered so inevitable that many authorities have recommended early primary subtalar fusion as the ideal treatment. Other, and equally competent, but somewhat less radical authorities, advocate subtalar fusion if there is any residual foot pain four months after injury. Still other authorities, mostly British, take a fatalistic attitude. They make no attempt at reduction at all, preferring to permit consolidation of the calcaneus prior to a secondary fusion only because of the technical difficulties encountered when a primary fusion is performed.

SYMPTOMS of a traumatic arthritis will be gradual in onset. In general, but not always, there will be bridging symptoms from the time of the accident. In the intra-articular fracture, symptoms referable to the joint may not begin until several weeks after the rehabilitative program has started. At that time, joint movement and muscle tone have started to return, but the function is generally impaired. Movement beyond a certain optimum results in pain, swelling, effusion, and instability. The patient then puts the part at rest. Because comfort may be at the expense of functional position, a contracture frequently results. On the other hand, many months, or even years, may elapse between the time of injury and the onset of symptoms. A typical example of this sequence of events is the flexion adduction deformity in traumatic arthritis of the hip, secondary to intracapsular fracture of the femoral neck. The fractured hip also frequently demonstrates the very slow development of symptoms as in the late aseptic necrosis of the femoral head. I have had one such patient who began to develop symptoms seven years after injury, and six years after she was discharged from treatment with a solidly healed fracture.

Up to this point I have been discussing fractures which involve articular surfaces. Fractures, however, are not the sole factor in the production of a true traumatic arthritis. Penetrating or perforating wounds, particularly those in which there remains, or is deposited, a

foreign particle or fragment within the capsule, are quite likely to produce an arthritis, even without the aid of an intermediate pyrogenic infection. Lacerations or detachment of the menisci are notorious for their production of arthritic symptoms. Ruptures or tears of the ligaments or capsule, such as are found in dislocations of the interphalangeal joints of the fingers, frequently result in a very disabling type of traumatic arthritis. Still another factor is the arthritis which derives from the presence of loose bodies within the joint. These may occur as the result of splitting off a piece of articular cartilage, with subsequent slow calcification, or the detachment of a piece of cartilage and subchondral bone, as in osteochondritis dissecans, or the formation of a pedunculated or detached synovial villus as seen in osteochondromatosis. The arthritic syndrome may be slow to develop because the irritative process will not begin, as a rule, until the loose bodies are caught between the articular surfaces. A single loose body which remains in the suprapatellar pouch may never give rise to symptoms.

PATHOLOGICALLY, there is nothing to distinguish the traumatic arthritis from any other. The marginal lippings, histologically, are exactly the same as those found in the chronic arthritis of the aged. The erosion and degeneration of the articular cartilage does not differ from the erosion seen in a gonococcal or a septic arthritis. The pathology may vary as one would expect, from minimal to severe, even progressing in some instances to complete fusion of the joint.

History and physical examination will usually make the diagnosis. The laboratory will usually report a normal sedimentation rate, blood count and urine. X-rays will reveal degenerative or hypertrophic changes. The diagnosis of traumatic arthritis is made entirely on an etiologic basis; there are no x-ray findings which differentiate it from a dozen other varieties. The presence of an old healed fracture with arthritic changes in the joint is more or less *prima facie* evidence that the process is secondary to trauma.

Treatment is approximately the same, and with the same limitations, as in osteoarthritis, since the lesion itself is practically the same. In this group, however, since the process is usually non-articular, we more frequently rely on surgery, either for the removal of the cause, if possible, or surgical fusion of the joint for elimination of pain. Relief of pain will be at the expense of loss of function. Frequently, a nice balance of medical judgment is necessary to determine which of the two, loss of pain, or loss of function, is more desirable.

NON-ARTICULAR RHEUMATISM

I COME now to that large group of musculoskeletal complaints not properly classified as joint diseases. Because of geographic proximity to joints, or by close approximation of symptomatology, they are frequently confused with arthritis. In most instances, the pathology is closely analogous to the early inflammatory process of arthritis. It is known as "non-articular rheumatism" and while the phrase itself is meaningless, still it does convey a general idea of the pathology and its location. Among this group are such syndromes as perifibrositis (which might better be called an adhesive capsulitis), subdeltoid bursitis, tennis elbow, tenosynovitis, reflex sympathetic dystrophy, olecranon and prepatellar bursitis, etc. We have all encountered these, almost invariably with a traumatic history. I think it is proper to state that trauma is, without question, the greatest single factor in the cause of this group of lesions.

With the exception of reflex sympathetic dystrophy the one thing common to all these is the synovial cell lining. It is difficult, if not impossible, for the pathologist to differentiate between the synovial linings of a joint, a bursa, or a tendon sheath. Even the anatomist will occasionally have difficulty in differentiating them, since bursae, and less frequently, tendon sheaths, do communicate with adjacent joints and for all practical purposes are part of them.

THE pathology is that of a low grade non-specific inflammatory process with hyperemia, edema, and infiltration of the synovial

and sub-synovial tissues. Frequently, nature is unkind enough to deposit amorphous calcium in these tissues, further increasing the inflammatory process by a foreign body reaction. The net result of this process is an adherence of adjacent structures to each other, where they should be gliding smoothly past each other. This adherence is almost universal. Even in those bursae which distend with fluid following a single trauma, there is, more often than not, on surgical section, a "compartmentalization" or division of the bursal sac by adhesions. A typical example of this adhesiveness is demonstrated by the "frozen shoulder" following an upper humeral fracture or a partial laceration of the rotator cuff.

A single, violent traumatic incident is not necessarily the etiologic factor in this group of cases. The causative agent may be a repetitious series of subminimal traumata as in the tenosynovitis of seamstresses and wire coil fabricators. Other examples of this are the metacarpophalangeal bursitis of boxers, the peroneal tendinitis of roller-skaters, and the capsular calcification of the ankle in soccer players.

Reflex sympathetic dystrophy, while classified with this group, is somewhat different in its pathology and patho-physiology. Weir Mitchell in 1878 first described this in a treatise on Civil War injuries. He postulated that it was due to a division of the nerve trunks, and he labeled it a "causalgia." Today, we realize that the basic cause lies not in the motor nerve trunks, but rather in the sympathetic innervation to the arterial trunks. It is apparently a reflex phenomenon. A single trauma to the foot, for instance, may be followed by causalgic symptoms throughout the extremity. The arterial spasm which results may cause generalized, or spotty decalcification of the osseous structures to such a degree that collapse of the subchondral bone occurs with resulting arthritic changes. This, of course, is comparatively rare; the symptoms are usually those of mild oxygen starvation to the extremity with its attendant pain. Stiffness of the joints occurs by reason of further vascular impoverishment of the normally poor fibrous structures about the joint. A common example is the bluish, cold,

stiff, painful, shiny atrophic foot and leg following a fracture of the foot or ankle.

THERE is no specific therapeutic modality for any of these except reflex sympathetic dystrophy. The symptoms of this may be markedly, sometimes permanently relieved, by lumbar or stellate ganglion blocks; or in the more resistant cases, by lumbar or cervical sympathectomy. In the rest of this group, sympathetic blocks may help relieve symptoms, but is not as specific as in causalgia. In this group, physical therapy offers its greatest benefit. Treatment will consist not only of machine physical therapy (such as diathermy, whirlpool baths, infrared), but will also include such modalities as assistive, supervised, or heavy resistance exercises.

Most instances of so-called exacerbation of a pre-existing arthritis belong to this group. They actually consist of a pre-existing osteoarthritis with a non-articular type superimposed upon it.

THE MISCELLANEOUS GROUP

THE factor which is common to the "miscellaneous" group, and which separates it from the non-articular group, is that, in general, these lesions are somatic or generalized in origin, but are capable of producing joint symptoms. This rubric will, of course, not include those groups of true arthritis, such as rheumatoid, since they are in a classification by themselves. We think in terms of extraneous diseases which may only incidentally produce arthritic symptoms. There is a great list of these: psoriatic arthritis is one example in which the arthritic symptoms are in proportion to the exacerbation and remission of the psoriasis. Another instance is the group of neurotrophic arthropathies, such as Charcot's joint, or the articular destruction due to a diabetic neuropathy. In neurotrophic lesions, pain will usually not be a factor, since the sensory nerves are primarily affected. Metastatic bone lesions and primary bone tumors which occur in close proximity to joints may occasionally also erode into the joint itself, or will produce

enough osteoporosis and bone destruction surrounding it that collapse of the articular surface will be inevitable. With highly malignant lesions, either metastatic or primary, the time between onset and death is usually not sufficient to allow gradual changes to occur. However, in the less malignant or benign tumors, the interval may be great enough to permit such changes. Such a lesion is exemplified by a myeloma, which, in single form must be considered benign, and when multiple must be considered slowly malignant. The pre-senile osteoporosis of the elderly individual, or of the not so elderly individual with hormonal imbalance, must also be included in this category. This lesion has a predilection for the spine. The calcium content of the bone is withdrawn from the matrix, with a consequent weakening of the basic structure of the vertebral body. Very frequently these patients will have gradual collapse and compression of one or more of

the vertebral segments, which may occur without any definitive trauma. However, any minimal trauma which would not be competent to produce a fracture in a normal spine, frequently will produce one in the osteoporotic spine. When this occurs in industry, or on the highway, it must be considered a traumatic fracture rather than a pure atraumatic lesion.

FOREIGN PROTEIN REACTIONS

*A*NOTHER common lesion is the true arthritic reaction due to foreign, protein, most particularly penicillin and tetanus antitoxin. The treatment of comparatively minor wounds in industry or on the highway with both antibiotics and tetanus makes this an always-possible complication. Many other lesions might also be included in this group but they rarely, if ever, give rise to court issues.

466 Park Avenue

Psychiatry for Clergymen

Your clergyman may be interested in attending five special lectures sponsored by and held at the Essex County Hospital at Cedar Grove, N.J. These will be on Tuesdays at 9:30 a.m. as follows:

- October 19—Orientation to Psychiatry.
- October 26—The Psychoneuroses.
- November 2—The Psychoses.
- November 9—Problems of Adolescence.
- November 16—Problems of the Older Citizen.

No fee or formal registration is required. However unless already entered in this course, the clergyman is asked to write to the Superintendent, Essex County Hospital, Cedar Grove, N. J. or to telephone VEona 8-1142, extension 222 or 212, so that space may be reserved and further details furnished.

HUGH F. LUDDECKE, M.D.

Morristown

Anemia Needs Specific Treatment

Dr. Luddecke deplores—and properly—the reckless and nonspecific administration of anti-anemic preparations without any attempt to ascertain the nature of the anemia. An anti-anemic drug is a precision tool and should be administered with specificity.

Too many patients are referred for hematologic investigation after prolonged treatment with incorrect (single or mixed) anti-anemic preparations. I have received information, too, that in this area the sale (on prescription) of mixed anti-anemic preparations is considerably greater than the sale of both iron and liver (including vitamin B₁₂) as separate preparations. Sometimes a patient is labelled "anemic" on the basis of a single hemoglobin determination! Or a blood count, with no serious evaluation of erythrocyte morphology, is used as the basis of such a diagnosis.

Our present diagnostic methods are good enough to permit specific therapy in many cases. Under these circumstances this careless use of the "anemia" label is not to our credit as physicians.

CLASSIFICATION OF ANEMIAS

THERE is no ideal classification of anemia.

From a clinical standpoint I have found the following very useful. It involves chiefly etiological factors, specific where known, and thus often implies proper therapy.

- A. Due to a specific deficiency.
 1. Macrocytic (megaloblastic) — need liver, B₁₂ or occasionally folic acid; and, in those above 35, careful study to rule out gastric neoplasm.
 2. Microcytic, hypochromic — need iron and infrequently hydrochloric acid (or cessation of oral alkalies).

3. Miscellaneous — scurvy, hypothyroidism, low protein intake, etc.
- B. Due to blood loss, acute or chronic.
- C. Due to excessive blood destruction.
 1. Congenital.
 2. Acquired.
- D. Due to exogenous causes — lead, volatile industrial chemicals, medicinal agents, etc.
- E. Due to cause or causes unknown.
 1. Associated with chronic infection.
 2. Associated with malignancy.
 3. Associated with marrow aplasia or hypoplasia.

This classification, and its point of reference, offers nothing new or unusual. But it does focus attention on the importance of diagnostic precision in the management of a patient with anemia. One should be relatively certain of the diagnosis in category A-1. That is why I have included a term (megaloblastic) that refers to cells found in the marrow. As regards a macrocytic anemia, occasionally with megaloblasts in the marrow, this can be seen in association with liver disease and certain gastro-intestinal diseases. Hence, finding macrocytic anemia is not an immediate indication for large doses of vitamin B₁₂. The patient should be thoroughly investigated and then followed with reticulocyte counts to determine the degree of response to the selected treatment. The diagnosis of pernicious anemia means that the patient will have to stay on medication for the rest of his life. He also should be investigated for spinal cord involvement. He is slightly more liable to

gastric carcinoma than those without pernicious anemia. Hence, it is a diagnosis to be arrived at only after exhaustive investigation.

REQUIRED TESTS

THE basic laboratory tests required in using this classification are, for the most part, available in any clinical or hospital laboratory. The basic tests are:

1. Blood count with carefully evaluated study of well stained films for red and white cell morphology.
2. Urinalysis.
3. Hematocrit.
4. Erythrocyte sedimentation rate.
5. Quantitative serum bilirubin (or icteric index).
6. Reticulocyte count.
7. Bone marrow aspiration.

There are, of course, many occasions when only two or three of these tests are necessary; and there are rare occasions when many more studies are required. Knowledge of the pathogenesis of anemia in many individual cases is still inadequate. But, to practice scientific medicine, we must thoroughly utilize what knowledge we have. These tests are to be used in conjunction with a complete and understanding clinical evaluation of the patient.

One of the problems not infrequently seen in the hematology laboratory is this: the young adult female with a hemoglobin of 12 Grams plus or minus 1, and a red count of 4.00 plus or minus 0.20. Her complaints are vague and consist of fatigue, lack of energy and "shortness of breath." This is generally of a "sighing" type, and not true dyspnea, indicating that the oxygen-carrying capacity of the blood is not actually decreased. These patients are too often given varying amounts of mixed anti-anemia preparations orally; or still worse, have been given "shots" with no relief of symptoms. Often these injections serve in a "ceremonial" manner to fix the incorrect knowledge of organic disease in the mind of the patient. Thus, it is evident that a complete and accurate blood count serves first to establish the presence or absence of anemia.

The hematocrit is inexpensive, easy to perform, relatively free of inherent error (prob-

able accuracy is plus or minus 3 per cent) and offers an excellent method for measuring the degree of anemia. The information thus obtained is used with the hemoglobin and red count in calculating the mean corpuscular values or blood indices. These values should agree with the picture obtained from the smears as to erythrocyte size and hemoglobin content.

Urinalysis gives one an idea as to kidney function and can suggest the possibility of occult renal infection. One of the more frequent causes of anemia in general hospital admissions is renal disease.

Another frequent cause is chronic infection and here sedimentation rate is frequently of some use. The mechanism of anemia in these two states is unknown. Treatment should be oriented to the underlying disease and not to one of its somatic manifestations.

SERUM bilirubin, if increased in the presence of anemia, immediately suggests a hemolytic process. If so, further examinations such as red cell fragility and Coombs test should be done. In this group of anemias, there are several valuable, although not exactly specific methods of therapy, such as splenectomy or the administration of cortisone.

The reticulocyte count is useful in that it measures the number of slightly immature erythrocytes present in the peripheral blood. When this is increased, it signifies greater demand on the marrow and indicates its ability to respond to this demand. This ability, however, cannot always be positively assumed from the reticulocyte count unless one can with certainty rule out extramedullary erythropoiesis. I do not believe the value of the reticulocyte count is fully realized or appreciated. Its chief uses are in measuring the erythropoietic functional integrity of the marrow and in assaying the adequacy of response to the specific therapeutic agent in pernicious anemia, iron deficiency anemia and anemia of hypothyroidism. In these conditions, it offers not only an additional check on the diagnosis, but also on the adequacy of dosage of the medicine and completeness of the diagnosis. As an example of the latter, it may be pointed out that, in an

anemic individual with hypothyroidism, the anemia is not always in a cause and effect relationship. Here, the lack of reticulocyte response following adequate thyroid administration would strongly suggest that one might look further for the cause of the anemia.

Bone marrow aspiration is a reliable diagnostic tool. This has been well established by many reports from large hospitals and medical centers. Its value and ease of accomplishment in a hospital of moderate size (235 beds) in rural New Jersey, I believe, has also been well established.

Morristown Memorial Hospital

SUMMARY

IN THIS era of scientific medicine, there is little need in our therapeutic armamentarium for "mixed" or "shotgun" anti-anemic preparations. Anemia is a measurable somatic manifestation of an underlying deficiency or disease. Before any therapeutic attempts are made, the exact nature of this underlying process should be sought. Frequently, this can be ascertained and then, of course, specific therapy will be successful and the results highly gratifying to patient and physician. This is our obligation.

Richardson Chemical Test for Pregnancy

Richardson, in 1951, reported a chemical test for pregnancy and claimed 99.1 per cent accuracy in over 2,500 tests. The test could be completed in half an hour and was proposed for office or clinic practice.

In a recent study, Roth and Leonard* have demonstrated the unreliability of this test. One hundred twenty-two pregnant women were tested with four negatives, an error percentage of 3.3 per cent. Among 78 non-pregnant women there were 34 positive reactions, an error of 43.6 per cent. The confirmatory

test for pregnancy employing meta-dinitrobenzene was equally unreliable, there being 9.8 per cent false negatives among the pregnant women and 74.3 per cent false positives among the non-pregnant group. It was concluded that as presently described these tests of Richardson's are inaccurate, unreliable and therefore not clinically useful.

* Roth, L. G. and Leonard, W. G., Jr.: The Unreliability of the Richardson Chemical Test for Pregnancy. U. S. Armed Forces M. J. 5:83, January 1954.

Hill-Burton Fund Allocation

Funds have been allocated to states for the first year's operations of the Hill-Burton expansion act, passed by the last Congress to stimulate the construction of health facilities. A total of \$21 million was made available by Congress, plus \$2 million for surveys. A total of \$6.5 million is set aside for diagnostic-treatment centers and the same amount for chronic disease facilities, and \$4 million for rehabilitation facilities and the same amount for nursing homes. Money must be used for diagnostic-treatment centers, nursing homes,

chronic disease hospitals, and rehabilitation facilities. Except for money earmarked for rehabilitation facilities, states are allowed to shift money from one category to another. The money is distributed to states on a formula taking into account per capita income of the states as well as their population.

The total allocated to New Jersey is \$328,000. Of this, \$64,000 is earmarked for rehabilitation facilities and another \$64,000 for nursing homes. The sum of \$100,000 is earmarked for chronic disease facilities and another \$100,000 for diagnostic centers.

PERRIN H. LONG, M.D.

Brooklyn, N. Y.

The Toxic Effects of Antibiotics*

Dr. Long warns us that sulfonamides and antibiotics can produce toxic side-effects. He deplores the casual, indiscriminating use of these agents. Use only when affirmatively indicated is the key to wise therapy.

PHYSICIANS and patients give too little thought to the possible harmful effects which may be produced by antibacterial agents, either when they are used rationally or, as sometimes happens, irrationally. This statement may be challenged because of my use of the words "too little thought," and "irrationally." However, let's take a look at the record.

First, I ask all of you here: How many times have *you* taken a sulfonamide or an antibiotic "to prevent" an upper respiratory tract infection from occurring? Or "to cure" such an infection? Or "to prevent" secondary infection from developing? As I am speaking to internists, I dare not ask you how many times you have administered sulfonamides or antibiotics to patients for these reasons! Now let us look at the record. The bacterial infections of the upper respiratory tract for which sulfonamides or antibiotics are useful therapeutic agents constitute a small minority of the total of upper respiratory tract infections. The vast majority of such infections are produced by the viruses of the common cold, influenza, or what has recently been called A.R.D. (Acute Respiratory Disease). *There is not one shred of controlled evidence that any of the currently available sulfonamides or antibiotics have an anti-viral effect against any of these viruses!* There is no controlled evidence that sulfonamides or antibiotics reduce the incidence of "secondary infection" in common colds, influenza or acute respiratory disease. Why do physicians administer, and patients demand antibacterial agents

in upper respiratory tract disease of viral origin? The answer has escaped me to date; but I believe that sometimes the irrational use of antibacterial agents arises from the fact that both the physician and the patient know that the patient will go elsewhere if he doesn't get a "wonder" or "miracle" drug just when he wants it. In other words, the doctor has lost control in this situation.

In the second place, I am appalled by the lack of thought frequently exhibited in prescribing or using antibacterial agents. Little attention is paid to getting a careful history about previous antibacterial therapy and possible reactions from that therapy. The fact that the patient has had asthma, hay fever, eczema or other allergic manifestations, is only too frequently discounted, when we know that such patients are prone to develop severe allergic reactions, especially to penicillin. Streptomycin and dihydrostreptomycin may produce eighth nerve injury. This is often forgotten. The danger of moniliasis when "broad spectrum" antibiotics are used is often not given sufficient thought. Sometimes, let us admit, the doctor is in a panic "to do something" for a patient who has a fever, while the cause of the disease has not been determined. This often results in the institution of a completely irrational regime of antibacterial therapy.

All of us should remember *that any anti-*

*From the College of Medicine at New York City, State University of New York, and the University Division, Kings County Hospital, Brooklyn, N. Y. This paper was read at the Annual Meeting of The Medical Society of New Jersey, May 17, 1954.

bacterial agent may be a poison for some patients and hence use thought, care and discrimination in the use of sulfonamides and antibiotics. If we do this, the incidence of the harmful effects of antibiotics will be lessened and the treatment of the patient and his infectious disease will be greatly improved.

THE HARMFUL EFFECTS

1. *Disturbances of the Skin.* All commonly used sulfonamides or antibiotics, with the probable exception of *tyrothricin*, *polymyxin B* and *Bacitracin*®, may produce eruptions of varying morphologic types and severity when used for the systemic treatment of infectious processes. Drug rashes appear to occur more frequently in patients who have had other manifestations of an allergic nature. Among the antibiotics, penicillin is the greatest offender, with the streptomycins coming next. The tetracyclins (*Achromycin*®, *Aureomycin*®, *Terramycin*®, *Tetracycl*®) and *Chloramphenicol*® rarely produce reactions of sensitivity in the skin. The same is true of *Erythromycin*® and *Carbomycin*®. It is my personal opinion that because of their propensity for producing contact dermatitis, topical preparations of sulfonamides, penicillin or of the streptomycins are undesirable. Skin eruptions may be accompanied by other manifestations of toxicity such as drug fever, and, with the sulfonamides, blood dyscrasias, etc. *It is my opinion that unless extraordinary conditions demand it, a patient who has had a skin reaction caused by an antibacterial agent should not be exposed to that agent again.* There is just too much risk involved.

2. *Disturbances of the Temperature Mechanism.* Any of the systemic sulfonamides and antibiotics may produce "drug fever." This fever may start shortly after the initial dose; or it may be days or even weeks before it appears. In my experience, the sulfonamides, penicillin, the streptomycins and polymyxin B have been the antibacterial agents most likely to produce drug fever. It appears to be uncommon when the tetracyclins, *Chloramphenicol*®, *Erythromycin*®, *Neomycin*® or *Carbomycin*® are used. It occurs occasionally when *Bacitracin*® is administered.

3. *Disturbances of the Oral Cavity.* These are rare with the sulfonamides. However, when troches and lozenges containing penicillin or other antibiotics are administered, "black tongue" and other oral disturbances may result. Broad spectrum antibiotics may result in a superinfection with monilia in the oral cavity.

4. *Disturbances of the Respiratory Tract.* Fatal anaphylactic-like reactions have been reported in patients who were receiving sulfonamides. Such reactions are being increasingly reported following the administration of penicillin. When procaine penicillin is used double jeopardy may exist, as fatalities can be due to hypersensitivity to procaine as well as to the penicillin. *It is my firm belief that patients who have had or have asthma, hay fever or other allergic manifestations should not be treated with penicillin, as a number of the reported sudden deaths from the administration of penicillin have occurred in such patients.* Also, as procaine sensitivity is an occupational hazard among dentists, their sensitivity must be determined *before* procaine-penicillin is administered to a dentist. When broad spectrum antibiotics are used in patients having a chronic basilar infection of the lungs, the possibility that this therapy may produce conditions which are favorable for a superinfection with monilia or other types of organisms must be borne in mind.

5. *Disturbances of the Gastro-intestinal Tract.* Nausea and vomiting may develop when a tetracyclin, *Erythromycin*®, *Carbomycin*® or *Chloramphenicol*® is prescribed. It may occur when sulfonamides are administered. There now seems to be less nausea and vomiting from these antibiotics than formerly, probably because smaller doses are being given. There is another interesting sidelight on this type of nausea and vomiting. It would appear that the more a patient has heard about the medication to be prescribed and the higher his integration, the greater the chance is that he will develop nausea and/or vomiting. In my experience, physicians, nurses, medical students, dentists, and their wives always have more trouble with nausea and vomiting when taking sulfonamides or antibiotics. Small children and felons seem to have the least difficulties.

Another problem arises from superinfection of the large bowel with yeast, molds or resistant bacteria (Staphylococci, Pseudomonas or Proteus) when broad spectrum antibiotics are being administered. Such superinfections may produce signs ranging from mild diarrhea to a severe and fatal entero-colitis.

6. *Disturbances of the Nervous System.* Sulfonamides have been reported as producing mental disturbances and acute psychoses. Peripheral neuritis of varying degrees of severity has also been described as a toxic reaction to sulfonamides. Intrathecal penicillin or streptomycin especially if the doses are large, may produce convulsions. Both are said to have produced peripheral polyneuritis. Streptomycin may produce temporary, and at times permanent, damage to the vestibular apparatus. Both streptomycin and dihydrostreptomycin can produce permanent deafness. With dihydrostreptomycin, this deafness may not appear until one, two, or even three months after therapy has been discontinued. Polymyxin B, in its upper dosage ranges, may produce paresthesias and anesthetics. I have seen ataxia develop in the course of treatment with this antibiotic.

6. *Disturbances of the Kidneys.* It is too often forgotten, that sulfadiazine, sulfamethazine or sulfamerazine may produce crystalluria, mechanical blocking of the ureter with sulfonamide crystals, or nephrosis of the lower nephron. When combinations of these three sulfonamides are used, the danger of renal injury is lessened. Other commonly used sulfonamides, such as, for instance, sulfisoxazole, have not in my experience produced renal injury. None of the antibiotics (with the exceptions of polymyxin B and Bacitracin®) produce renal injury. The latter two may produce injury to the renal tubules, clinically evident by the appearance of albumin, red blood cells, white blood cells and casts in the urine, and a rising non-protein nitrogen in the blood, when doses which are excessive for the individual patient are employed. In general, if the daily doses of either of these two anti-

biotics are kept within the range recommended in *New and Non-official Remedies*, evidences of renal damage will be rare. Still, it is a good practice to examine the urine daily when either polymyxin B or Bacitracin® are being prescribed.

8. *Disturbances of the Blood and Blood-forming Organs.* Any of the commonly used sulfonamides may produce acute hemolytic anemia, primary anemia, secondary anemia, aplastic anemia, leukopenia, granulocytopenia, agranulocytosis, thrombocytopenia, purpura or queer leukemoid states. While these reactions are seen much less frequently than previously, when sulfanilamide, sulfapyridine or sulfathiazole were the sulfonamides of choice, the physician must remember that these reactions *do* occur and be on the lookout for them. As far as my knowledge goes, Chloramphenicol® is the only antibiotic which has been implicated as producing blood dyscrasias. Leukopenia has been noted in patients receiving Chloramphenicol®. It has also been reported that this antibiotic has produced aplastic anemia. To date, controlled statistical evidence on this point is still lacking. However, physicians should keep this possibility in mind when they are considering the prescription of Chloramphenicol®.

9. *Disturbances of the Liver.* Sulfonamides on rare occasions produce a toxic hepatitis. As far as my knowledge goes, none of the antibiotics has produced this type of reaction.

CONCLUSION

THE sulfonamides currently being used will produce toxic reactions at exactly the same rate as five, ten or twelve years ago. Of the commonly used antibiotics, penicillin seems to be the greatest offender today as far as toxic reactions are concerned. *Neither sulfonamides nor antibiotics should be prescribed unless there is definite clinical or bacteriologic evidence that such a prescription will benefit the patient.* Otherwise, the physician has no one but himself to blame if his patient develops a toxic reaction.

The Physician and the Blue Cross Plan

KENNETH E. GARDNER, M.D.

This item is offered to clear up possible points of confusion or misunderstanding concerning the organization, growth, and operation of the Hospital Service Plan of New Jersey, whose president, Mr. Theodore Sorg, has been of great assistance in its preparation.

The organization and growth of the Hospital Service Plan of New Jersey — the 'Blue Cross Plan'—during the past twenty one years has been one of the outstanding achievements in the field of medical economics. It has provided the people of New Jersey with a prepayment plan which protects the family income from unexpected or prolonged expenses for hospitalization.

The New Jersey Blue Cross Plan is a non-profit organization and is under the supervision of the Department of Banking and Insurance of New Jersey. The Plan has been so well operated that in the past only 8 per cent of each subscription dollar was actually used to pay operating costs, thereby leaving more than 91 per cent available to pay the cost of hospitalization for its subscribers.

A new Comprehensive Contract (Series 1953) is replacing outstanding Subscription Contract (Series 1949) on anniversary dates. This new Contract provides payment in eligible cases for essential hospital services for treatment of Plan patients. It does *not* provide for diagnostic services, nor for any other hospital services, unless such services are in connection with and consistent with actual treatment of the eligible diagnosed condition of the patient.

One of the prime features of the new Subscription Contract is the elimination of hospital charges for so-called "extras" for certain hospital services. The elimination of these charges for "extras" means savings to the patient, control of some unwarranted charges, and extension of the inclusive service feature to the patient. It also assures payment to the hospital for these eligible extended services.

The Blue Cross payment to Contracting

Hospitals for hospital services includes room, board, drugs and laboratory and x-ray examinations related to the immediate care and treatment of the patient, and the use of other hospital equipment and facilities eligible under the Contract. The private room patient pays the difference between the private room rate and the highest semi-private room rate. Except for this differential, the private room patient is entitled to the same inclusive service provided the patient in semi-private or ward accommodation.

Blue Cross payment to the hospital is on the basis of its average *per diem* rate calculated either on basis of costs or collected charges, within the agreed-upon limits. When the cost to the hospital exceeds this *per diem* rate as agreed upon between Blue Cross and each hospital, the hospital must either accept the loss or negotiate with Blue Cross for an increase at regular intervals. Any increase, however, if granted must be reflected eventually in increased premium rates or a reduction of hospital services—neither of which is desirable to the physician, patient, or Plan.

Extra services for Blue Cross subscribers should not exceed in number and cost those for non-Blue Cross subscribers. Many hospitals, however, report that more extra services are ordered by attending physicians for Blue Cross subscribers than for non-subscribers. These extra services are usually due to requests for additional laboratory and x-ray diagnostic services which are not in connection with, or consistent with, or not directly related to the immediate care and treatment of the diagnosed condition for which the patient was admitted. With the New Jersey Blue Cross handling nearly 20,000 admissions a month, a saving of unnecessary services on

even one-tenth of the admissions amounts to a considerable sum.

Just one extra day of hospitalization per Blue Cross patient would cost the New Jersey Blue Cross Plan \$375,000 a month — \$4,500,-000 per year!

The Blue Cross Plan must depend upon the continued support and judgment of each

individual physician to determine which hospital services are essential to the immediate care and treatment of the patient, and to eliminate purely diagnostic services. Through the cooperation of all the physicians of New Jersey, the future success of the Blue Cross Plan can be maintained at the lowest possible premium rates to the subscribing public.

Obituaries • • •

DR. JOSEPH J. COSTANZO

Dr. Joseph J. Costanzo, county physician to the County of Camden, died after a long illness on August 20. Born in Philadelphia, Dr. Costanzo became a track star at Villanova. He then attended St. Louis University from which he received his M.D. degree in 1936. He practiced in Clementon, N. J. and was active in the Camden County Medical Society, and also in the County Chamber of Commerce. Dr. Costanzo was 45 years old at the time of his death.

DR. NICHOLAS FALVELLO

Dr. Nicholas Falvello, who, at one time or another, was medical attendant to Jack Dempsey, Mickey Walker and Georges Carpentier, died in Miami on August 24. Dr. Falvello, a member of the Morris County Medical Society, had been on the urological services at Overlook Hospital in Summit and All Souls Hospital in Morristown. Born in Brooklyn in 1885, he was a member of the class of 1914 Albany Medical College. He then came to Morristown where he was in practice from 1916 to 1950. He was medical officer for Welch's (later Madame Bey's) training camp in Chatham, where trained some of the best known boxers in the world.

Dr. Falvello moved from Morristown to Miami in 1950 because of ill health. However, he obtained a Florida license and continued in a limited practice almost to the very day of his death.

DR. GEORGE FRIEDBURG

At the untimely age of 50, Dr. George Friedburg died of a heart attack at his home in Elizabeth on August 21, 1954. Born in Russia in 1904, he came to this country as a boy. In 1929 he earned his M.D. at the medical school of Georgetown University in Washington. He interned at St. Elizabeth's Hospital in Elizabeth. He was on the staff of that hospital as well as of the Alexian Brothers Hospital, and he was active in the affairs of the Union County Medical Society.

DR. JOSEPH METSKY

On September 1, Dr. Joseph Metsky, Associate Obstetrician at the Newark Beth Israel Hospital, died of a heart attack at his home in Newark. Born in Russia in 1896, Dr. Metsky came to the U.S.A. as a boy and in 1936 was graduated from the medical school of the University of Tennessee. He was active in the affairs of the Associate Staff Organization of the Beth Israel Hospital, and was a long-term member of the Essex County Medical Society.

DR. SAMUEL L. SLOAN

On August 25 the editor of this JOURNAL received a manuscript on cigarette smoking by Dr. Samuel Sloan of Paterson. The next day we read a newspaper account of Dr. Sloan's death. A graduate of Long Island College Hospital, he was 61 years old at the time of his death. He was a charter intern at the Barnert Hospital in Paterson. He was in the Army Medical Corps in World War I.

Dr. Sloan was a surgeon. He did graduate work at the Mayo Clinic and was an F.A.C.S. He was also much interested in public health (as tokened by his little paper on smoking) and for 25 years he was Health Officer of Haledon, N. J. He was active in the Passaic County Medical Society.

DR. LLOYD C. STICKLES

Dr. Lloyd C. Stickles died at the St. Barnabas Hospital in Newark on September 2, 1954. Born in Clifton Forge, Virginia, in 1886, Dr. Stickles was graduated from the College of Physicians and Surgeons (Columbia University) in 1913. After intern-ing at the Clara Maass Hospital in Newark, he settled down here and went into general practice. He was on the staff of the old Hospital for Women and Children, and was active in staff affairs at St. Barnabas. He was a member of the Essex County Medical Society.

Announcements • • •

New Jersey Cancer Seminar

The second Annual Cancer Seminar of the American Cancer Society, New Jersey Division, will be held at Hotel President, Atlantic City, October 16 and 17. Speakers and their topics include:

Dr. Hayes Martin, Memorial Cancer Center, New York City, "The Diagnostic Significance of a Lump in the Neck"; *Dr. John H. Gibbon*, Jefferson Medical College, Philadelphia, "Prospects for the Control of Lung Cancer"; *Harold L. Stewart*, National Institute of Health, Bethesda, Md., "The Epidemiologic Approach to the Cancer Problem"; *Dr. John B. Graham*, Vincent Memorial Laboratory, Boston, "Objective Criteria for Selection of Therapy in Cancer of the Cervix."

Dr. Oliver Cope, Massachusetts General Hospital, Boston, "Diagnosis and Treatment of Tumors in the Thyroid"; *Dr. Theodore J. Curphey*, Meadowbrook Hospital, Hempstead, N. Y., "Pitfalls and Hazards in the Technic of Biopsy"; *Dr. Maurice Fremont-Smith*, Massachusetts General Hospital, Boston, "The Detection of Cancer in the Physician's Office"; *Dr. Alexander Brunschwig*, Memorial Cancer Center, New York, "The Radical Surgical Approach to Lesions of the Upper Gastrointestinal Tract"; *Dr. B. Phillip Custer*, Presbyterian Hospital, Philadelphia, "Brighter Aspects of Leukemia" and *Dr. Perry B. Hudson*, Columbia University, College of Physicians and Surgeons, New York City, "The Diagnosis and Treatment of Cancer of the Prostate."

Sessions begin Saturday afternoon and conclude Sunday at 4 p.m. Special rates at the hotel for the October week-end have been arranged by the Professional Information Committee of the New Jersey Division of which Dr. Joseph I. Echikson, of Newark, is chairman.

Symposium on Hand Injuries

On October 21, the Industrial Medical Association and the N. J. Academy of Medicine will sponsor a joint symposium on injuries of the hand. The discussion will be led by Dr. J. W. Littler, Associate Plastic Surgeon at the Roosevelt Hospital in New York. The meeting is scheduled to start at 8.45 p.m. All physicians are welcome.

Want To Display a Scientific Exhibit?

Any member interested in presenting a scientific exhibit at the 1955 Annual Meeting may obtain an application form by writing to Administrative Secretary, Medical Society, 315 West State Street, Trenton 8, N. J.

Trudeau Society

The American Trudeau Society will hold a scientific session at the Hotel New Yorker, New York City, on November 17, 1954 from 9 a.m. to 5 p.m. The meeting will be open to physicians interested in pulmonary diseases in internal medicine, surgery and pediatrics, and to scientists in allied disciplines. The program will consist of presentations on various aspects of pulmonary diseases from the clinical and laboratory standpoints.

Thyroid Research Prize

The American Goiter Association offers a \$300 award for the best essay on a problem related to the activity of the thyroid gland. Known as the "Van Meter Prize," the award will be announced at the next meeting of the Association in April 1955. The essay must not exceed 3000 words and should be submitted in duplicate (double spaced) to Dr. John C. McClintock, 149 Washington Ave., Albany, N. Y. Deadline for submitting the paper is January 5, 1955. Further details may be obtained from Dr. McClintock.

Crippled Children's and Adults' Convention

"Rehabilitation for Independence" is the theme of the Annual Meeting of the National Society for Crippled Children and Adults in Boston, November 2 to 5. Speakers include Howard Rusk, Senator John F. Kennedy, Dr. Margaret Mead, Dr. William C. Menninger, and also, the Treasurer of the United States, Mrs. Ivy Baker Priest. For full details, write to the National Society for Crippled Children and Adults at 11 South LaSalle Street, Chicago 3, Illinois.

Diabetes Colloquium

Highlight of diabetes detection activities for 1954 is the diabetes colloquium scheduled for Wednesday afternoon, October 27, at the Academy of Medicine in Newark. The program follows:

- 2:00 p.m.—Greetings from Dr. G. M. Knowles, President, New Jersey Diabetes Association.
- 2:10 p.m.—“Diabetes, A Public Health Problem.” Daniel Bergsma, M.D. State Commissioner of Health.
- 2:30 p.m.—Diabetic Retinopathy. Arthur Linksz, M.D., New York City.
- 2:50 p.m.—Diabetic Nephropathy. Harold Rifkin, M.D., New York City.
- 3:10 p.m.—Diabetes in Children, Priscilla White, M.D., Boston.
- 3:25 p.m.—Vascular Complication of Diabetes. Gerald Pratt, M.D., New York City.
- 3:45 p.m.—Intermission.
- 4:00 to 5:00 p.m.—Panel Discussion, moderated by Benjamin Saslow, M.D., Governor of the American Diabetes Association for New Jersey. Speakers above-listed constitute the panel.

Dr. Joseph Skwinsky and Dr. Otto Brandman,
Co-chairmen

Fireproof Standards for Nursing Homes

Available from the Board of Fire Underwriters (85 John St., New York 38, N. Y.) is a new booklet which details fire-proofing standards for Nursing Homes, Old Age Homes, Convalescent Homes and similar small institutions.

Cancer Symposium

At 8:30 p.m. at the New York Academy of Medicine, there will be held on November 4 (Thursday) an unusual symposium and colloquium on cancer. The program has been set up in four units: (a) Incidence of cancer and the changes in such incidence over the years; (b) Views about the cause of cancer; (c) The diagnosis of cancer; and (d) Modern treatment of cancer. Some of the country's leading authorities are participating. This is the 1954 Suiter Lecture. Dr. A. Walter Suiter, who died in 1925, left to the New York Academy of Medicine an endowment fund for annual lectures on public health.

Like To Live in the Canal Zone?

Announcement has been made of vacancies for physicians on duty with the Panama Canal Zone Government. Family quarters and U.S. oriented schools up to the junior college level are available. The salary is from \$7400 to \$10,450 a year depending on the doctor's experience. Service is in general hospitals or district dispensaries. If interested obtain forms 15, 57 and 5001 from the Civil Service Commission in the Federal Building, Christopher Street, New York 14, N. Y., or from the Civil Service Commission in the Customs House at 200 Chestnut St., Philadelphia 6, Penna. Send the completed form, airmail to Chief Civil Service Examiner, Balboa Heights, Canal Zone.

A.C.S. Meets in New Jersey

The annual Clinical Congress of the American College of Surgeons, will be held in Atlantic City, November 15 to 19. This graduate education meeting will present recent surgical developments through panel discussions, symposia, surgical forums, motion pictures, color television and exhibits. Dr. Charles deT. Shivers, Atlantic City, is Chairman of the Committee on Arrangements.

Dr. Frank Glenn, New York, current President of the American College of Surgeons, will preside at the opening evening session, at which Dr. Alan Gregg, New York, and Dr. Robert H. Kennedy, New York, will be guest speakers. On the final evening Dr. Alfred Blalock, Baltimore, will be installed as President for the coming year.

Federal Positions Now Available

Physicians interested in a career of Government Service may now apply for appointments as general practitioners or as specialists. The salary range is from \$6000 to \$10,800 a year depending on specialization, experience, and station selected. Positions are available in Washington, D.C., in the Panama Canal Zone, and in nearly all parts of the United States. For more details apply to the U. S. Civil Service Commission, either at the Philadelphia office (200 Chestnut St., Philadelphia 6, Pa.) or at the New York Office (Federal Building, Christopher St., New York 14, N. Y.)

Abbreviations: Booby Traps of Medical Writing

Each month in this space, the Publication Committee or the Editor will present a problem in medical writing. Here, too, we will answer questions about the JOURNAL in particular or medical writing in general.

What does P. A. mean to you? Paralysis agitans, if you are a neurologist. Pernicious anemia if you are an internist. Postero-anterior if you are a radiologist. The public relations officer thinks it means "public address system." My dictionary says that "P. A." is an abbreviation for Passenger Agent, proto-actinium, power of attorney, prothonotary apostolic, *pro anno*, and Purchasing Agent. "But," you protest, "most of these are non-medical meanings. The symbols P.A. in a medical article cannot be misunderstood."

They can. Indeed, take it as a rule of writing as well as a rule of life that anything that *can* be misunderstood *will* be misunderstood.

It is hard to persuade the doctor that the abbreviation which is so clear to him can be obscure to another. I often write to authors to ascertain what an abbreviation means, only to be greeted with hoots of disbelief. Surely I must know that P.M.I. meant "point of maximum impulse." I didn't, and out of the first ten doctors I buttonholed in the staff-room, only two reacted immediately to P.M.I.

One author was indignant when I would not allow him to say that he applied B.S. to the bruise. He was sure that everybody, but everybody, knew that B.S. meant Burow's Solution. But it could mean breath sounds, or bachelor of science, Barnes' speculum or basilar sinus, balance sheet or bill of sale . . . and that does not exhaust the possible meanings of B.S. either.

The ophthalmologist assumes that O always means eye, but to the pharmacist it stands for pint, to the chemist it means oxygen. A hematologist tells me that in *his* field no one misunderstands the abbreviation O. Of course it means a blood group without agglutinin. In electrotherapy it means the "opening" of the switch, the turn of the button which lets the current flow.

The last man in the world to judge the understandability of the abbreviation is the author of the article. Filled as he is, with his

subject he assumes that what is obvious to him is clear to every one. The cautious writer follows a simple rule: *when in doubt, spell it out!*

This is not only in the interest of clarity, but also in the interest of making a paper easier to edit. If you write "the dose is 5 gr.," and the editor wants to spell it out as "five grains," he will swear softly at you. For he has to crowd eleven symbols ("five grains") into the space in which you had placed three (5 gr.). But if you wrote "five grains," and in editorial whimsy, he wanted it to be "gr. 5," then he could easily cross out your words and find ample room to write in the three symbols. Every editor gets frequent borderline papers: manuscripts that are not quite good enough to get into the top drawer nor so obviously hopeless as to warrant return-mail rejection. Some editors (not me, of course) would, in a borderline case, reject the manuscript that is too troublesome to edit. So the rule again is "when in doubt, spell it out." Not just during "be kind to editors" week, but always.

ONE of our members once lost a prize because

he used a misunderstood abbreviation. At least, so he tells me. He was writing of diarrhea and made one reference to *E. histolytica* and another to *E. nana*. Since these abbreviations are not acceptable, I had to spell out that "E." The author meanwhile had gone off to Europe. Well, I knew what *E. histolytica* meant. After all, I, too, had been to medical school. So, if *E. histolytica* was *Entameba histolytica*, then obviously *E. nana* (who also caused diarrhea) was *Entameba nana*. And so it appeared in the JOURNAL. But, as an indignant author wired me from Europe, "*E. Nana*" is "*Entolimax nana*" which, he said, any fool should know. And the Award Committee of the Diarrhea Association passed over that paper on the theory that any one who thought "nana" was an ameba could not be much of a diarrhea specialist. The author always blamed me, but I still say it was his own fault for using an abbreviation.

Another abbreviation problem concerns itself with dosage terms. The smallest unit in both systems is a word that begins with "Gr."

This could mean grain, or it could mean Gram. Zweibel* recently reported the case of a woman who got fifteen times the prescribed dose because the pharmacist read 0.25 grains as 0.25 Grams. Here the rule is rigid: spell it out, and write Gram with a capital "G" and "grain" with a small "g." There are, to be sure, "official" abbreviations. But "dr" gets confused with "gr." and minims with millimeters. So the only safe rule is spell it out. Probably only one reader in a thousand would miss "100 mg. per cc.," but for his sake take the trouble to write out "100 milligrams per cubic centimeter." It really takes very little additional time. If the journal at which you are aiming does happen to use abbreviations, the editor will insert them easily enough.

Incidentally, the symbol "%" is used only in tables. In text, write it out: 27 per cent. Never "27%." The symbol for degrees is hardly necessary. If you say the patient's temperature rose from 98.6 to 101.3, no one will misunderstand. If you add a little "o" for degrees, the printer might misread it and add the "o" to the number. And some proof-reader might miss the error. If you still think it could be misunderstood, write out "degrees." This would certainly be the way to do it if you are referring to motion at a joint: 45 degrees, for

instance, not 45°. Spell out "minus" and "plus" when referring to basal metabolism or to other test results. Few typewriters have a "plus" symbol and the "minus" symbol is easily misunderstood as an ordinary dash.

One of an editor's (and reader's) pet peeves is the colon or dash to indicate a proportion. "Dissolved in 1-1000 saline," or "the ratio is 1:1000." It is so easy to spell it out: "in 1 to a thousand saline;" or "the ratio is one to a thousand." So with the "x" in expressing dimensions. "The tissue measured 22 x 56 x 83 cm" is better expressed in plain English, thus: ". . . measured 22 by 56 by 83 centimeters."

Pharmaceutical abbreviations cause trouble too. Such symbols as "t.i.d.," or "q.s." may be crystal clear to you. But I have seen "q.s." set as "qt." And "t.i.d." is a mystery to those of the current crop of medical students who are taught to do all their prescription writing in pure English.

Abbreviations belong in tabulations and in telegrams. If you use an abbreviation in text, it may be WR. That means "wrong," not warehouse receipts or Wassermann reaction.

HENRY A. DAVIDSON, M.D. *Editor,*
THE JOURNAL.

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Grenz Ray Therapy. By Gustav Bucky, M.D. and Frank C. Combes, M.D. Pp. 204. New York, Springer Publishing Company, 1954. (\$8.50)

The anxiously awaited book on grenz ray therapy is now available. The authors, Dr. Bucky, an outstanding roentgenologist and physicist and Dr. Combes, a leading clinical dermatologist have pooled their information and joined it to contributions from other experts in physics, histology, tropical diseases, oral diseases, and ophthalmology.

Grenz rays are defined as radiation having a half value layer of up to 0.035 mm. of aluminum (35 microns). Above this we begin to deal with the more superficial forms of x-ray. The absorption curves of radiation produced at various kilovoltages are presented. From these and the histologic studies of treated skin, the relative safety of grenz radiation over x-radiation has been demonstrated. X-ray over dosage results in central sclerosis and extensive peripheral capillary proliferation. Grenz

radiation overdosage produces a central fibroblastic proliferation and far less peripheral capillary proliferation. Epithelial hyperplasia or neoplasia can be eliminated from the sequelae of grenz ray effects.

In this book, the technic, dosage, and prescribed half value layer are given for each skin disease or each associated group of diseases. Throughout the therapy sections, the relative safety of grenz radiation over x-radiation is emphasized, particularly in chronic recurrent dermatoses. The effectiveness of the softer radiation is reported to be equal to or greater than that of x-ray. The most spectacular results presented are in the field of treatment of vascular nevi. Here "before and after" pictures show some remarkable results.

In another section, experimental work is presented showing that the eye can be treated safely with grenz radiation. In all, the book well covers the field of grenz radiation from theory to the methods of treatment.

SEYMOUR L. HANFLING, M.D.

*Zweibel, Leonard, in press.

Today's Health

The New Jersey Auxiliary, usually so progressive in most areas, has not done as well as it might with the sale of subscriptions to *Today's Health*—the official lay publication of the A.M.A.

Our parent organization, the A.M.A. Auxiliary, each year offers us a choice of programs for consideration. The only one which may be termed a "required" project is the sale of *Today's Health*. It should be described as "required" because it is the sole program in which we enter into direct competitive effort with our sister Auxiliaries throughout the nation. And, willy nilly, with the advent of the annual convention our state president must report New Jersey's progress in this activity. In addition to this, there is a mathematical individual who makes up and displays a chart showing percentage of quotas attained by each state. It has become automatic for us to look at the bottom of the prominently displayed chart for our state name. Recently our score was 27 per cent of quota.

The primary aim of each county auxiliary

is a program of health education under the control of the county medical society. Constantly, the county auxiliaries are engaged in raising funds for their pet projects — nurse scholarship, A.M.E.F., etc. The lively sale of *Today's Health* will go far toward improving both situations.

There is no better way to foster broadened health education than increased perusal of *Today's Health* by the lay people in your community. Similarly, one of the easiest ways to increase your Auxiliary income is through the sale of subscriptions to *Today's Health*.

There is a large market for subscription sales: Auxiliary members, physicians (indisputably the most popular waiting room magazine) dentists, teachers, librarians; and all people avid for authentic health information.

If each physician in New Jersey purchased a subscription through his local auxiliary, we would have our 100 per cent of quota and all "out of family" sales would be profit. Renewals count, too.

Mrs. Asher Yaguda, Chairman

Auxiliary Report • • •

Essex County

Mrs. Philip D'Ambola, of Harrison and Montclair, president of the *Woman's Auxiliary to the Essex County Medical Society*, held her Re-organization Board Meeting at the Forest Hill Field Club, Bloomfield, on June 15, 1954.

Following cocktails and a savory luncheon, Mrs. D'Ambola introduced the members of her Executive Board.

Mrs. Thomas A. Santoro, of East Orange, gave a resume of plans for a luncheon and bridge to be given for the benefit of the American Medical Education Foundation. It will be held at the Woman's Club of Orange on February 14, 1955.

Mrs. Harry DiGiacomo of Newark, program chairman, announced plans for the coming year. Highlights of the year will be:

October 25—Fall luncheon

November 20—Chrysanthemum Ball at Military Park Hotel

March 15—Public Relations Day

Mrs. George Parell of Newark, chairman of Ways and Means, announced that the principal fund-raising affair of the year, the annual Chry-

santhemum Ball will be held at the Military Park Hotel on November 20, 1954. Mrs. Parell reported that the first meeting of the Dance Committee was held at her home on June 10, 1954 to formulate plans for the Dance.

Mrs. Frank Galioto of Bloomfield, chairman of Public Relations Day, is arranging for a panel of interesting and informative speakers on the subject of "School Health." It will be held at the Orange Woman's Club on March 15, 1955.

Mrs. D'Ambola asked approval of the Board to establish a Guardian Committee for student nurses in order to establish closer relationship between student nurses we have placed in Schools of Nursing and the Auxiliary. The committee is to consist of approximately three members and the new member added each year would be the Nurse Scholarship Chairman of the previous year.

We are looking forward to an active and inspiring year under our capable new president.

MRS. THOMAS A. MESSINA,
Chairman, Press and Publicity

MRS. JOSEPH DINORCIA, Co-Chairman

Supplied by New Jersey Trudeau Society

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXVII

October, 1954

No. 10

THE STAGE IS SET—A Program for More Effective Control of Tuberculosis in the United States

By James E. Perkins, M.D., *National Tuberculosis Association, April, 1954.*

The year 1954 marks the fiftieth anniversary of the National Tuberculosis Association, the anniversary of the nationwide fight against tuberculosis in the United States. The campaign against tuberculosis as conceived by the founders of the National Tuberculosis Association is nationwide in scope but the basic unit is the local, self-governing tuberculosis association. The local associations work together in democratically constructed state associations. The National Association serves the state and local associations, coordinates their efforts, and carries on those responsibilities which can be handled only by a national body.

As the leader of the volunteer forces in the war against TB, the National Tuberculosis Association coordinates the efforts of more than 3,000 voluntary tuberculosis associations and aids them to re-examine, strengthen, and expand their programs for better service in accordance with local needs; works with its affiliated associations and supplies them with the health education materials needed to spread knowledge about the tuberculosis problem; advances scientific knowledge about tuberculosis through its medical section, the American Trudeau Society; works for the improvement of rehabilitation services for patients; promotes efforts to find cases of tuberculosis; stimulates the maintenance of adequate official health, welfare, and educational agencies; promotes the recruitment and training of skilled professional personnel for tuberculosis control; cooperates with all the forces fighting tubercu-

losis; and seeks to improve international efforts to control tuberculosis.

The activities of the voluntary tuberculosis association in communities throughout the United States are financed by the annual sale of Christmas Seals. Of the total proceeds, 94 per cent is used by the associations within the states where the money is raised. Six per cent is allotted to the National Tuberculosis Association.

When the NTA was founded in 1904, TB was the major health problem, the first cause of death in this country. Tuberculosis is now the sixth cause of death (1950). This decline represents great progress, but even a brief summary of the present situation indicates the seriousness of the problem today.

Tuberculosis is a totally unnecessary disease. It can be prevented. It can be cured. Yet, tuberculosis remains a leading cause of death in the age group from 15 to 34—decisive years in the lives of young people. Tuberculosis is one of the greatest killers among the American Indians and among Americans of Spanish descent. The death rate among Negroes is three and a half times the rate among whites. Tuberculosis kills approximately twice as many men as women. TB mortality is high among people who receive public assistance and inmates of mental and other institutions.

But the TB problem is not as adequately stated in terms of death as it is of living people—the 400,000 people who have active TB today. They may not die of tuberculosis, but they will have to live with the disease and with the inevitable changes it brings. Within the next year, about 100,000 people will catch TB. We are not preventing the *spread* of tuberculosis.

What does a "case of tuberculosis" mean? It means a suffering human being with a chronic, debilitating disease; a person who may have to undergo a long period of hospitalization; young people whose hopes may be blasted.

Tuberculosis must be considered not only in terms of its cost in lives and in human suffering. Its cost in money is important to the economic life of the country. The total TB bill in the United States is conservatively estimated at more than 600 million dollars a year! This figure includes the cost of case finding, care of patients, public health nursing, health education, rehabilitation, medical research, pensions to veterans, and public assistance to patients' families.

Most of this comes out of the taxpayer's pocket. The rest is borne by private agencies, individuals, and their families. The cost of one case of tuberculosis is difficult to determine. However, a rough estimate is \$15,000, including medical care, compensation, pensions, relief payments and loss of wages.

Tuberculosis is caused by a germ, the tubercle bacillus, which is spread usually through the air by persons with active disease. Many adults have at some time come in contact with the tubercle bacilli, but the disease has made headway in only a fraction. Approximately 800,000 persons are believed to have inactive tuberculosis. The disease has been arrested, either spontaneously or by medical treatment. Although the disease may remain in this arrested state, these people must have regular medical supervision. Together with the estimated 400,000 active cases, they constitute a group of 1,200,000 people who need medical supervision. Of the 400,000 active cases, about 250,000 are known to health authorities. The other 150,000 are the "unknown" cases—the people whose disease has never been reported.

According to a 1953 survey, 130,000 hospital beds are set aside for tuberculosis patients in the U. S., including 22,000 in mental and penal institutions. If all the unknown cases of TB were

found and all patients who refuse hospitalization were to accept it, they would be unable at the present time to get hospital treatment. Yet, modern medical opinion stresses the importance of hospital treatment of the tuberculous.

There is no simple solution to the problems of tuberculosis control. The mere spending of more money will not solve them. We need to improve further our over-all program of tuberculosis control in which official and voluntary agencies join in a concentrated, cooperative effort.

Such a program includes:

Greater efforts to find all cases of tuberculosis. Case finding among high-prevalence groups—such as admission to general hospitals, certain racial and national groups, mental patients—must receive priority and be intensified.

Greater efforts to make the best techniques of modern TB treatment readily available to all patients. This means provision of adequate hospital beds and supervision when hospitalization is impossible. It means improved education of the medical, nursing, and ancillary professions. It means better education of patients. It means medical research for further knowledge about tuberculosis. It means rehabilitation.

Greater efforts to build up the resistance of people to tuberculosis infection. Specific resistance calls for medical research to find a superior vaccine and wider use of our best present vaccine, BCG, in the groups most vulnerable to tuberculous infection. Improved nonspecific resistance calls for more education of the general public in nutrition and other aspects of healthy living.

This, then, is the program for tuberculosis control in this country. *It is difficult—it is ambitious. It is necessary.* Every case of tuberculosis is an indictment against society—irrefutable evidence that someone, somewhere was either ignorant or callous to his responsibility in preventing unnecessary human suffering.

The stage is set for total victory. There must be no faltering at this critical point!

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1. Best, C. H., and Taylor, N. B.: *The Physiological Basis of Medical Practice: A Text in Applied Physiology*, ed. 5, Baltimore, The Williams & Wilkins Company, 1950, pp. 579-583.

2. Bargen, J. A.: *A Method of Improving Function of the Bowel*, *Gastroenterology* 13:275 (Oct.) 1949.



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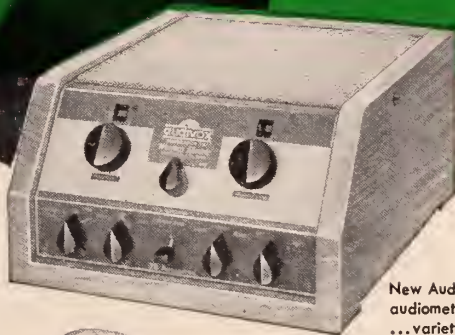
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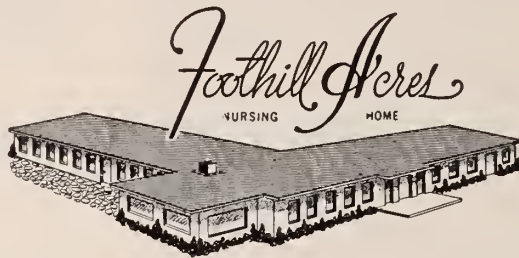
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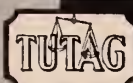
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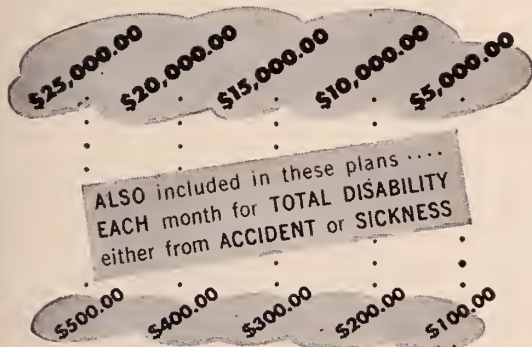
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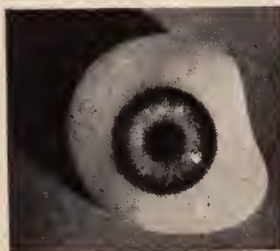
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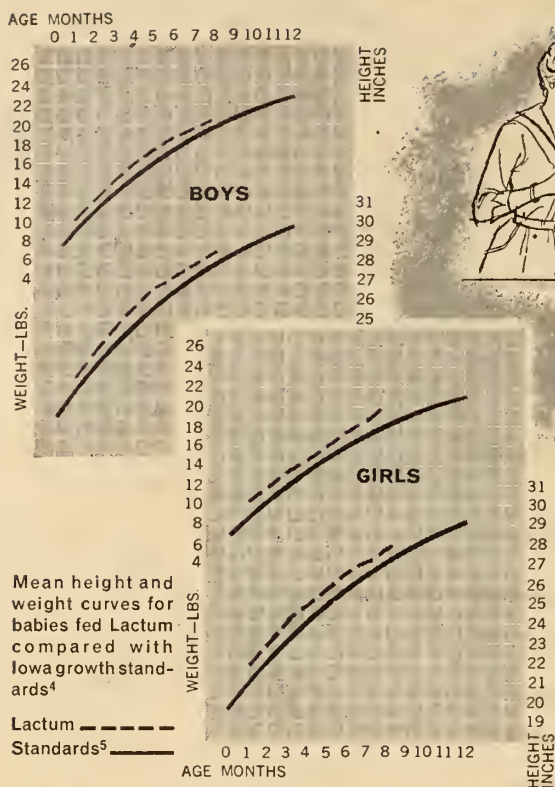
*Kaufman, R. H.; Mendelowitz, S. M., & Ratzan, W. J.: *Am. J. Obst. & Gynec.* 65:269, 1953.

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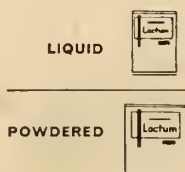
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(1) Jeans, P. C.: In A.M.A. Handbook of Nutrition, Ed. 2, Philadelphia, Blakiston, 1951, p. 275. (2) Albanese, A. A.: *Pediatr.* 8: 455, 1951. (3) Holt, L. E., Jr., and McIntosh, R.: In *Holt Pediatrics*, Ed. 12, New York, Appleton-Century-Crofts, Inc., 1953, pp. 175-178. (4) Frost, I. H., and Jackson, R. L.: *J. Pediatr.* 39: 585, 1951. (5) Jackson, R. L., and Kelly, H. G.: *J. Pediatr.* 27: 215, 1945.

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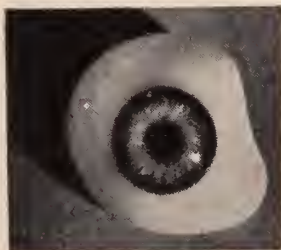
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*Heck, W.E.; Lynch, W.J., and Graves, H.L.: *Acta oto-laryng.* 43:416, 1953.

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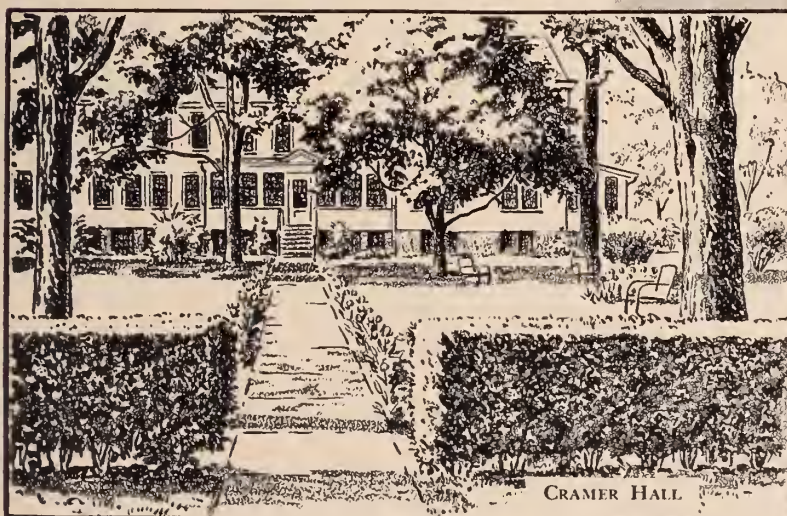
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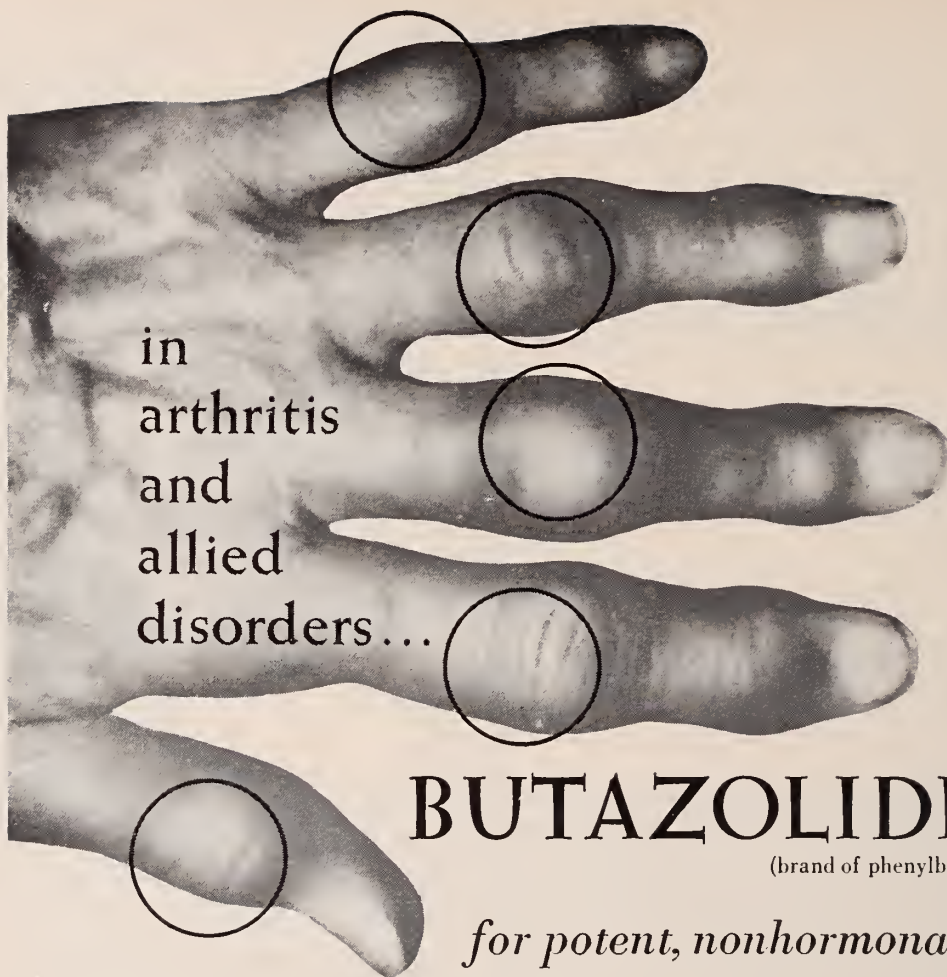
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*MacKnight, J. C.; Irby, R., and Toone, E. C., Jr.: *Geriatrics* 9:111 (Mar.) 1954.

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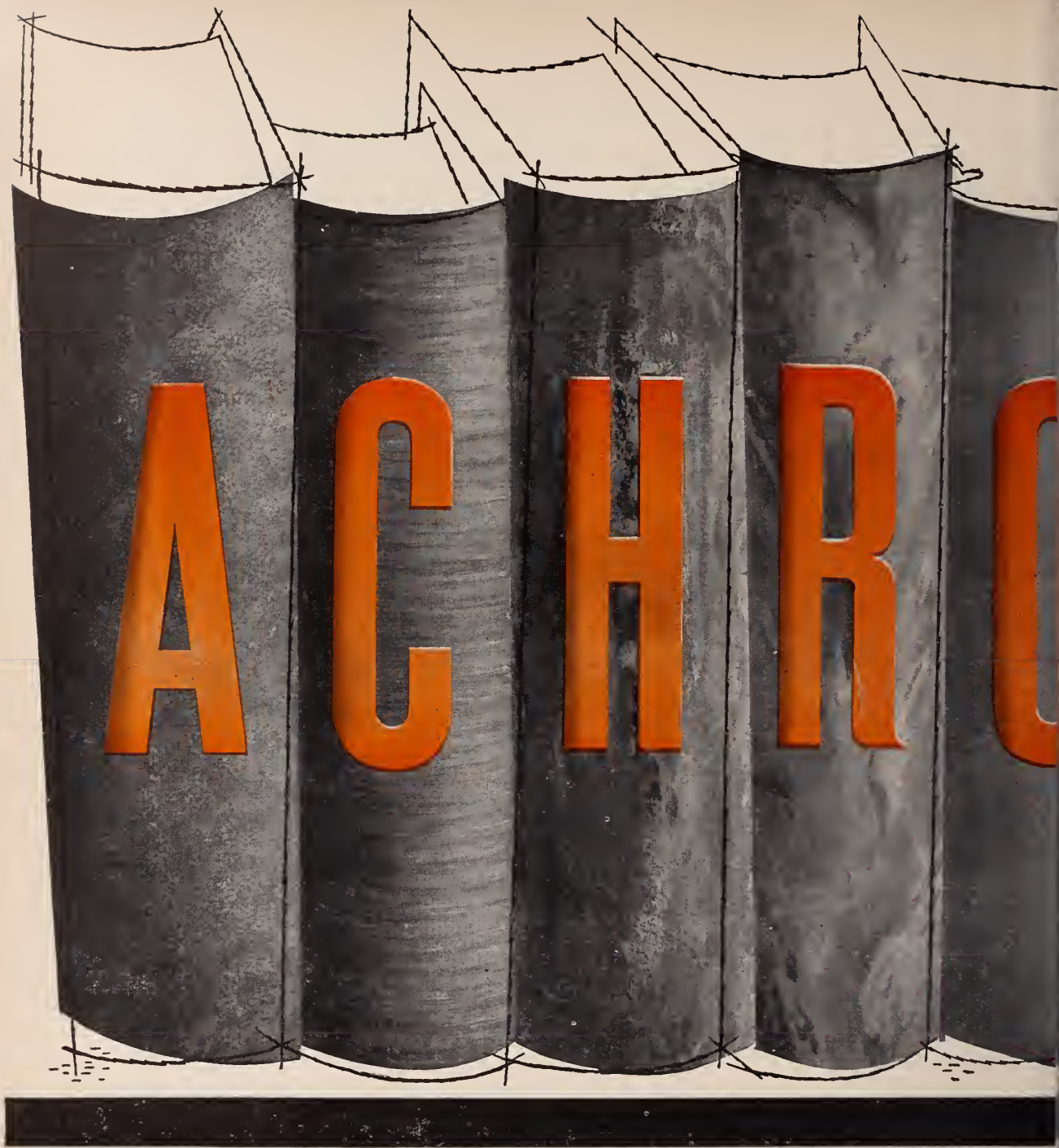
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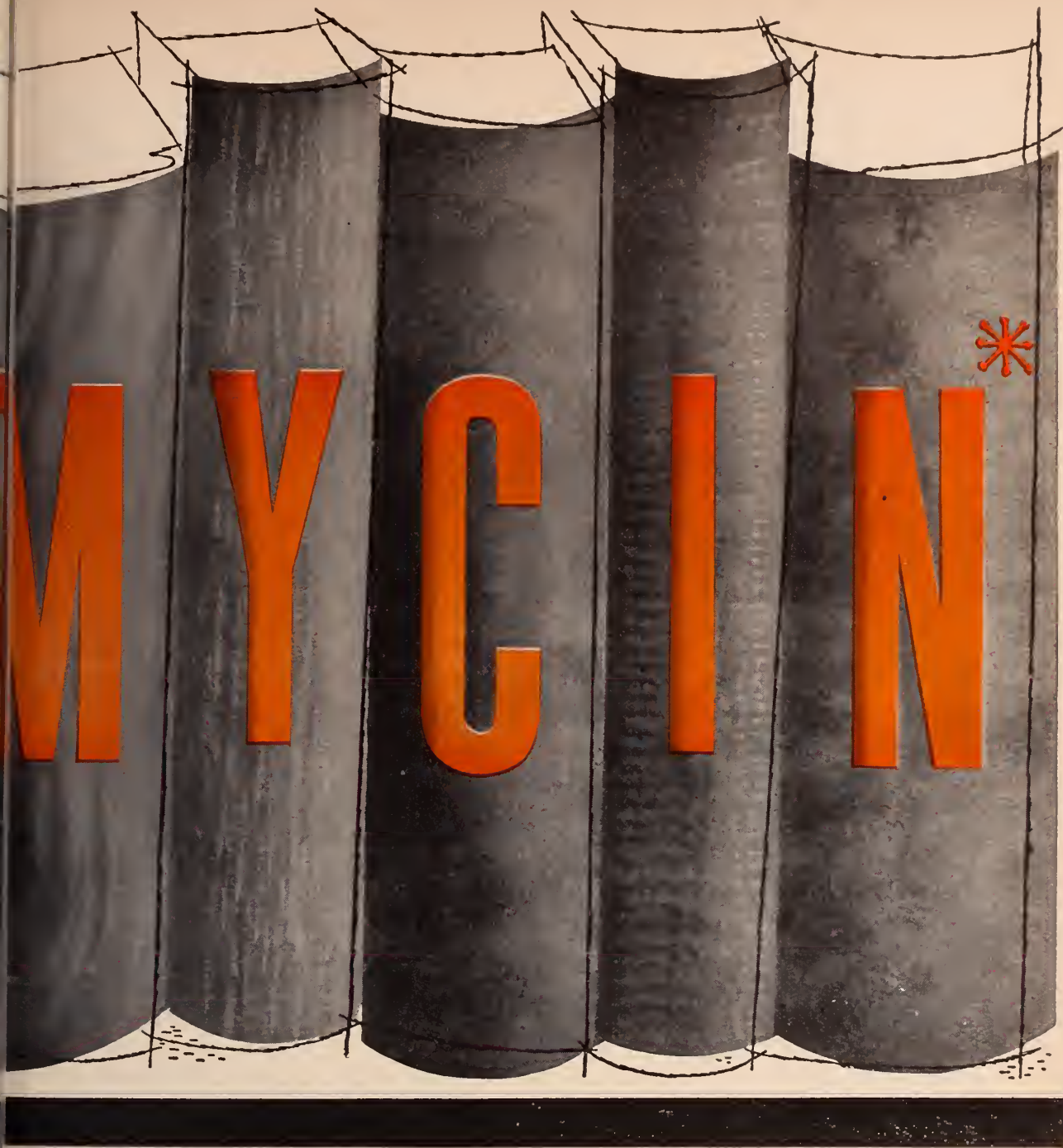
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1. Allen, E.V.; Barker, N.W.; Hines, E.A., Jr.; Kvale, W.F.; Shick, R.M.; Gifford, R.W., Jr., and Estes, J.E., Jr.; Proc. Staff Meet. Mayo Clin. 29:459 (Aug. 25) 1954.

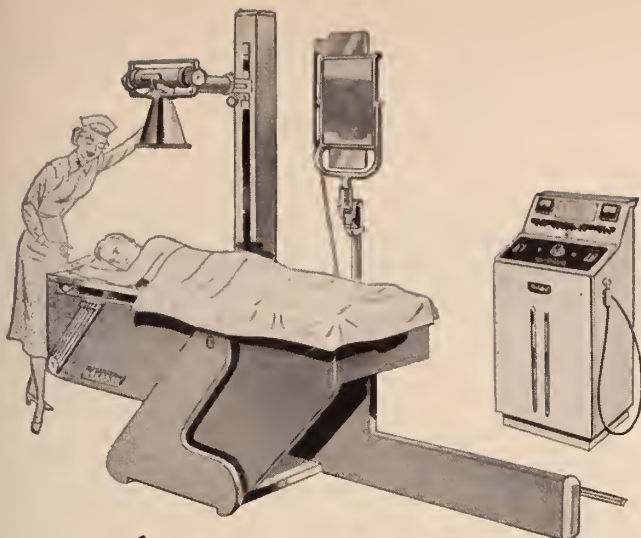
2. Livesay, W.R.; Moyer, J.H., and Miller, S.I.; J.A.M.A. 155:1027 (July 17) 1954.

3. Wilkins, R.W.: Mississippi Doctor 30:359 (Apr.) 1953.

4. Kert, M.J.; Rosenfeld, S.; Mailman, R.H.; Westergart, J.P.; Carleton, H.G., and Hiscock, E.: Angiology 5:318 (Aug.) 1954.



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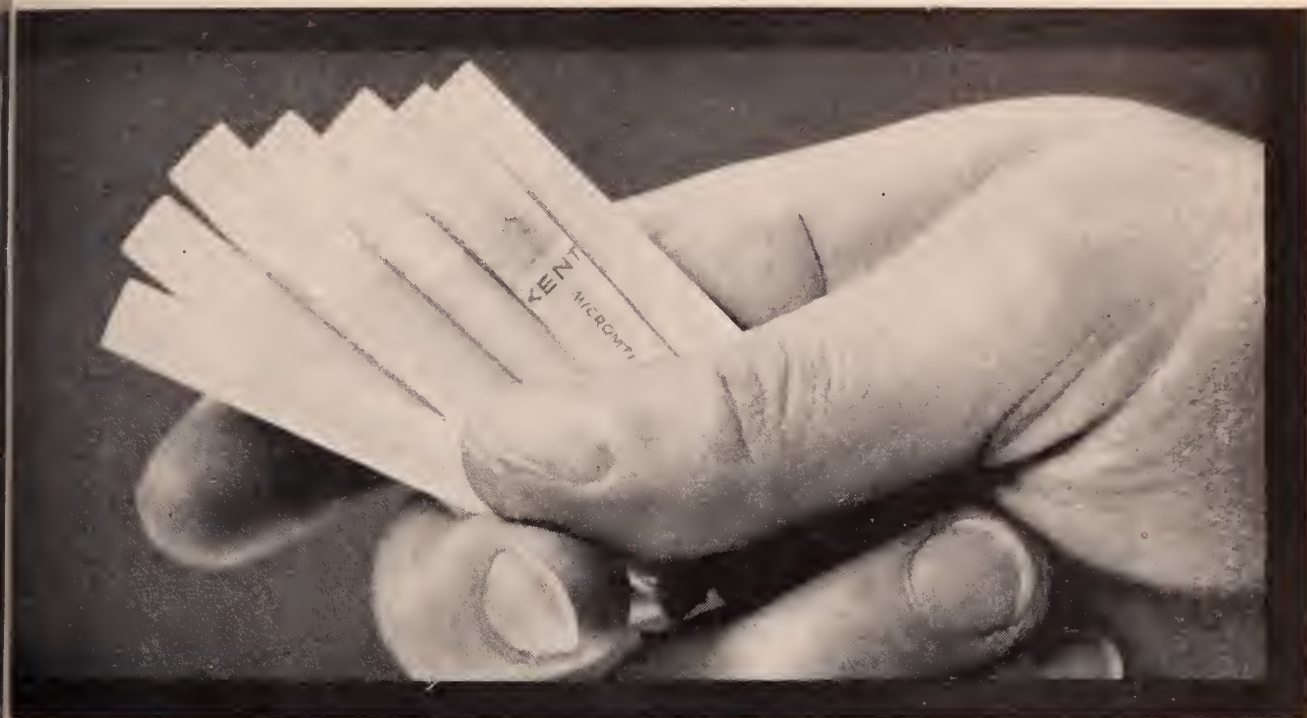
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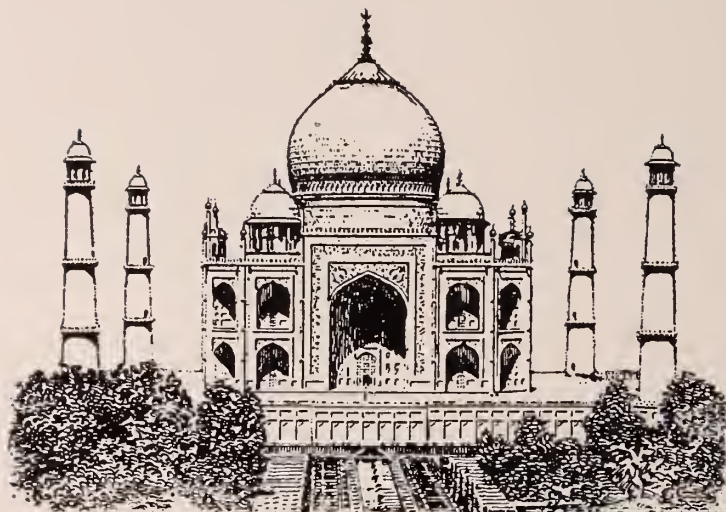
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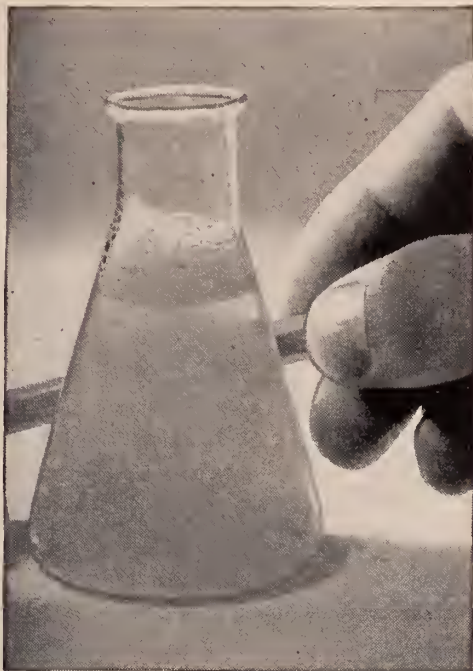
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1. American Medical Association: *New and Nonofficial Remedies*, 1954. J. B. Lippincott Co., Philadelphia, p. 147
2. Scott, R. L., and others: *Antibiot. & Chemo.* 4:691 (June) 1954



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1. Goldsmith, G. A.: Application to Human Nutrition, in Bourne, G. H., and Kidder, G. W.: *Biochemistry and Physiology of Nutrition*, New York, Academic Press Inc., 1953, chap. 23, p. 505.
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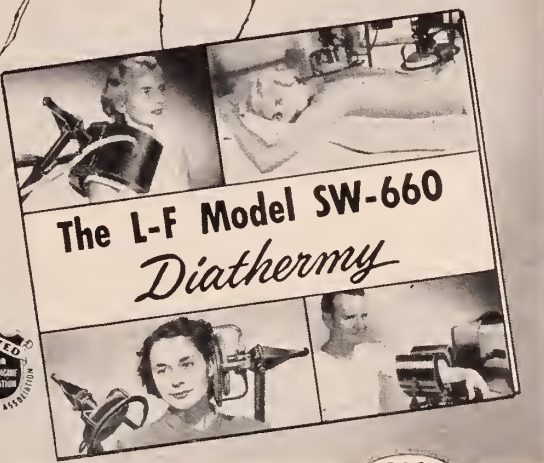
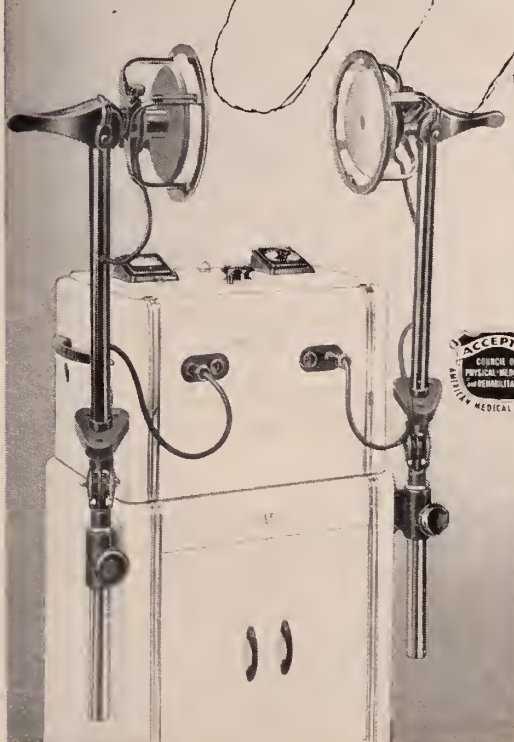
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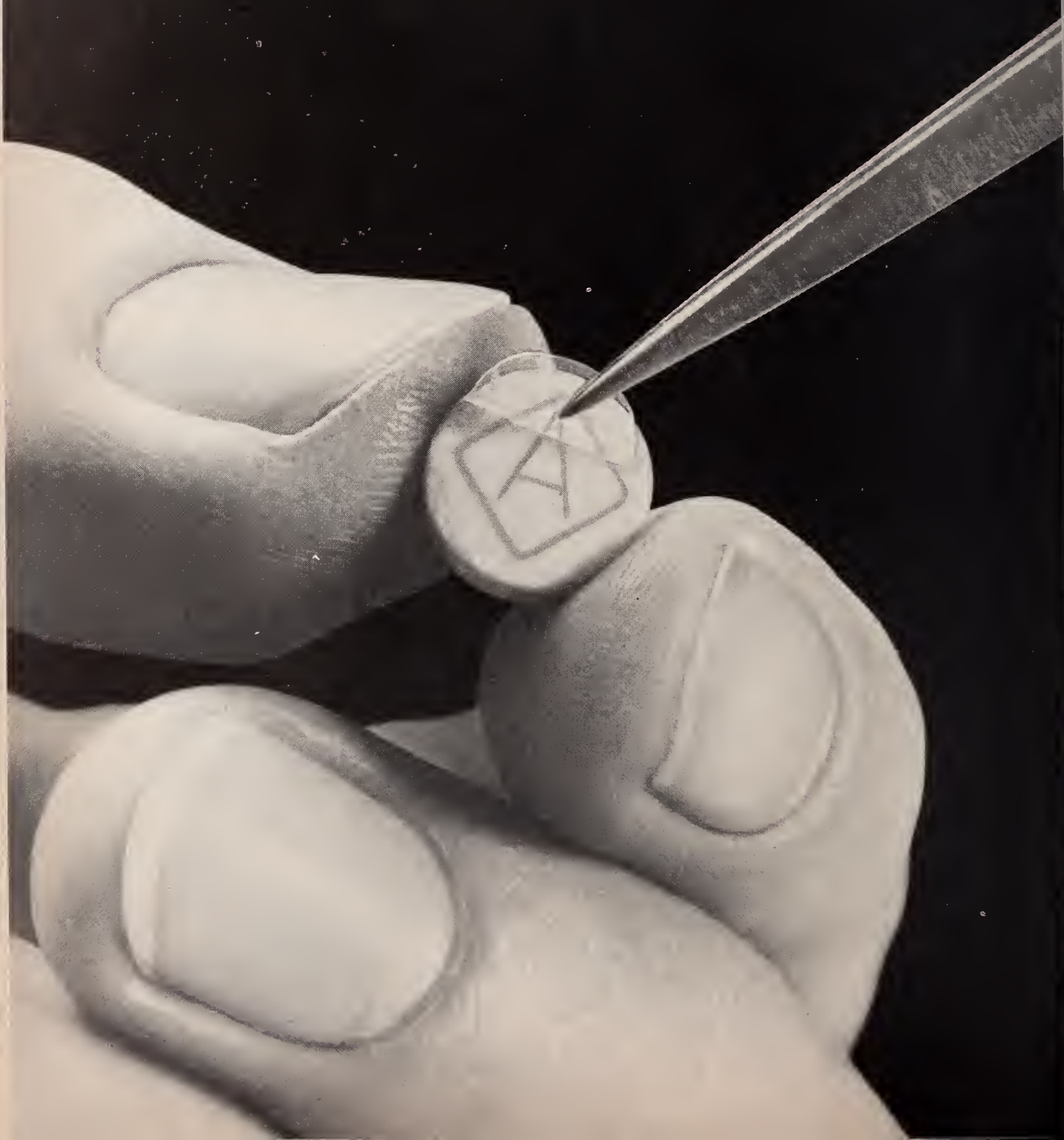
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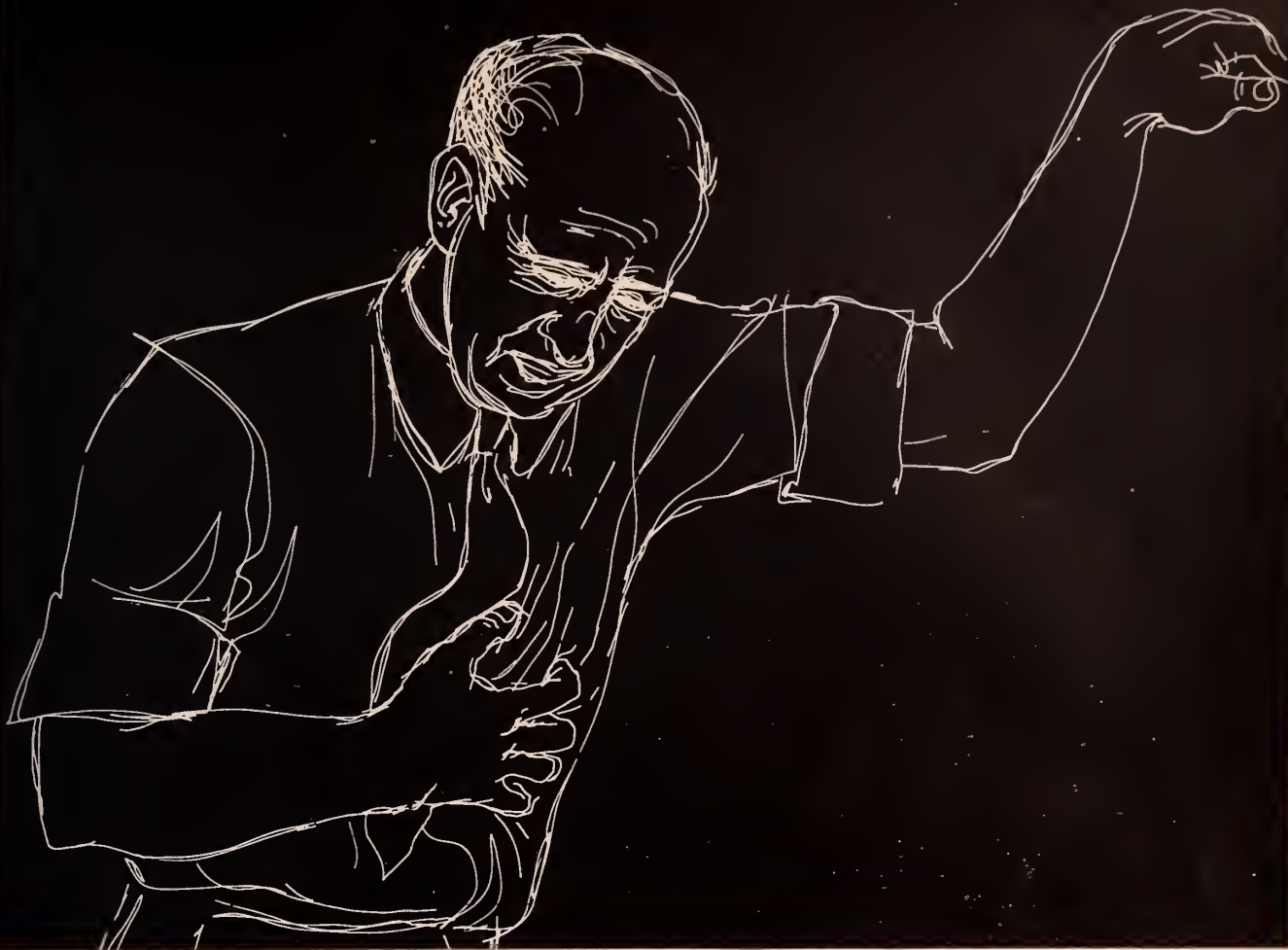
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References:

1. Russek, H. I.; Urbach, K. F.; Doerner, A. A., and Zohman, B. L.: J.A.M.A. 153:207 (Sept. 19) 1953.
2. Winsor, T., and Humphreys, P.: Angiology 3:1 (Feb.) 1952.
3. Plotz, M.: N. Y. State J. Med. 52:2012 (Aug. 15) 1952.

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Patients presenting such classic menopausal symptoms as hot flushes cause little diagnostic difficulty. However, throughout the period of declining ovarian function which may begin long before hot flushes appear, many women complain of distressing symptoms which though less clearly defined are actually due to estrogen deficiency. For example, insomnia, headache, easy fatigability, and symptoms affecting the bones, joints, and the skin may not be readily identified as due to estrogen deficiency because they may occur years before, or even years after cessation of menstruation.

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1. Werner, A.: Acta endocrinol. 13:87, 1953.

2. Malleson, J.: Lancet 2:158 (July 25) 1953.

3. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 23.



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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Old Remedies and New

In what was apparently pure coincidence rather than puckish humor, the *Journal* of the A.M.A. published in the same issue (July 17, 1954) one article which indicated that old home remedies might be dangerous and another indicating that they might contain mysterious alambics which could help control disease. The dangerous one was alfalfa seed tea. The presumably helpful one was the old Indian snake-root remedy.

Dr. William Kaufman found that a great many people are taking alfalfa tea for arthritis and diabetes. The A.M.A.'s Council on Pharmacy cannot find any evidence that alfalfa tea helps either condition. Dr. Kaufman finds plenty of evidence that alfalfa seed tea can give the drinker a stubborn dermatitis.

But if the old home remedy is beaten down in Roanoke, Virginia—where Dr. Kaufman comes from—it rears its head happily in Texas where, presumably, everything is twice life size anyway. Doctors Livesay, Moyer and Miller, all from Houston report that the old Indian snake-root remedy contains (assuredly to the

vast surprise of the braves and squaws) appreciable amounts of alseroxylon. And alseroxylon gives promise of lowering blood pressure, allaying anxiety, promoting mild sedation and improving the sense of well being. All without side effects. The raw product, of which alseroxylon is the extract, has the interesting botanical name of *Rauwolfia serpentina*, or, more commonly, just the Indian snakeroot drug.

And so it may be. But the deep laughter from the corner is the ghostly echo of the old pitchman, the vendor of the Indian Snakeroot Medicine. Remember what names we used to call him! History has travelled full cycle. He is with us again, sporting a *bona fide* M.D., and making his pitch not from the tailboard of his wagon but in the hallowed pages of the A.M.A. *Journal*. No, not quite. Because in the same issue of the same journal, appears the derogation of alfalfa tea.

That July 17 *Journal* is stripping away all our delusions. It even says that there is no such thing as an athletic heart. What *can* a man believe?

PUBLISHED MONTHLY SINCE 1904

Under the Direction of the Committee on Publication

J. LAWRENCE EVANS, JR., M.D., *Chairman*

HENRY A. DAVIDSON, M.D., *Editor*

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VOL. 51, No. 11

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The Nation's Medical Manpower

How many physicians *are* there in the United States? Would you say 75,000? Or is it 125,000? Or, perhaps, nearer a quarter of a million? Right the last time. The number is 218,522 according to a recent release from the American Medical Association.

To continue the guessing game, what proportion of these are in private practice? About 70 per cent? Or 80 per cent? Or 90 per cent? Right the first time: 71 per cent, to be exact. In round numbers, the breakdown is:

Private practice	156,000
Interns and residents	29,000
Government services	17,000
Not practicing	9,000
Research and teaching	7,000

That last line includes only doctors who devoted full professional time to teaching, research, insurance medicine or industrial health.

This gross number—218,522—is an all time high. However, the proportion who are essentially private practitioners is slowly falling. This is inevitable. The Government establish-

ments which need doctors are expanding. Industrial medicine is expanding. Research and teaching facilities are being stepped up. All these programs divert physicians from private practice.

In an average year about 7,200 new physicians are licensed and about 3,400 physicians lose the battle to their sworn enemy, the Angel of Death. This means a net annual gain of about 3,800 new M.D.s. It means 3,800 against a base of about 220,000—an increment of about 2 per cent a year. This is a sizable and steady growth, keeping well in pace with the growth of population. No other large country in the world can come anywhere near our high physician-patient ratio. No other country can report a consistent 2 per cent per year increment in its supply of physician man-power. While there may be no justification for smugness, it is also fair to point out that there is no need to view with alarm. Here and there a family in a particular location may have trouble finding a doctor in a hurry. But on the whole, the distribution and ratios are healthy.

"Medically Approved"—

"Medically approved" is the magic phrase in advertising today. Buy this relaxing chair: your doctor recommends it. Our brand of toilet paper is certified by leading dermatologists to be kind to your skin. So with cigaret holders which filter out the poison, air conditioners which control your climate, and background music which soothes your nerves. A triangular pillow is approved by neurologists as aiding relaxation and a mattress has been accoladed by orthopedists as leading to better posture. There is even a new seat cushion which interposes its foamy self between your ischial tuberosities and the seat of your chair. This too bears the unofficial approval of an anonymous and—just

possibly—nonexistent doctor. So fashionable is this today, that only a reckless retailer would open a store without a physician-in-waiting to give his sanction to the shoes, cigarettes, scallions, and light bulbs which he might sell.

In a way it is a double tribute to the physician. A tribute first because it suggests that the layman does respect the opinions of his doctor. And a tribute in another way too: it would be so easy for the practitioner to wander slightly off the reservation and accept a fee for endorsing something. So easy, that it is heart-warming to note how few M.D.s really do it.

ROBERT J. GROSS, M.D.

Newark

Private Practice Use of Radio-Isotopes

Radio-isotopes are now, under certain limitations, available to the private practitioner. Radio-iodine is useful in determining thyroid function and in treating hyperthyroidism. Phosphorus 32 has some value in certain blood dyscrasias. Dr. Gross here spells out the indications for, and limitations of the use of this 20th century modality.

THE generalized clinical application of radioactive isotopes was authorized in 1946. After a slow start, necessitated by limited facilities for training, hospital use is now becoming widespread. The Atomic Energy Commission, which has primary responsibility of the supervision and the use and distribution of these isotopes, has also inaugurated a program making radio-isotopes available to the private physician. Among the conditions set up by the commission* are that:

- (1) The isotope be applied "usefully."
- (2) Suitable facilities be available for protection of health and safety.
- (3) Suitable training of applicant qualifying him to use radio-isotopes. This applies to all personnel who may participate actively.
- (4) The applicant be a licensed physician.
- (5) He have access to a hospital possessing adequate facilities to hospitalize and monitor patients if necessary.

In promoting participation by the private practitioner, the commission has set up safeguards to ensure proper training before authorizing a physician to use radio-isotopes. At the outset, it is simpler for radiologists, par-

ticularly those with training in roentgen and radium therapy, to meet the requirements. However, it is not the policy to restrict these isotopes to one class of physician. Leading hospitals and universities are being encouraged to provide sufficient training to give *all* physicians who wish to qualify the necessary background for the use of radio-isotopes.

WHAT ARE RADIO-ISOTOPES?

THE name radio-isotopes is commonly applied to the artificially produced elements which spontaneously disintegrate and in doing so give off alpha, beta, or gamma rays. The medical profession has been schooled in the use of similar substances since the discovery of radium. The behavior of the artificial radio-isotopes is the same as radium; but each has its own scheme of disintegration, type of particle or ray given off, energy content, and so on. Knowledge of the physical characteristics of the radio-isotopes used is essential. A consultant physicist may be necessary to set up techniques, advise on radioactive waste disposal, check equipment, and provide liaison with the medical aspects of the enormous physics research program in atomic energy.

*Radio-isotope Distribution, an unofficial compilation by the Isotope Division, Atomic Energy Commission, Washington 25, D. C., January 15, 1954.

RADIO-ISOTOPE GLOSSARY

Radioactivity is the process during which a substance changes spontaneously or under the impact of high energy particles such as are present in the atomic pile or cyclotron; and during disintegration gives off energy in the form of alpha, beta, gamma rays, or other types of particles and rays.

Half Life Period is the length of time it takes a quantity of a radioactive substance to disintegrate to one half its original strength.

The half life ($L_{1/2}$) is characteristic for each isotope and follows an exponential law. In the first half-life half remains; in the second half-life period, only a fourth of the original amount is present. Third period: one eighth and so on. If excretion is disregarded, after 6.6 half-life periods, activity would be approximately 1 per cent of initial value.

Average Life ($L_{av.}$) is the predicted average time of existence of an atom of a radio-isotope before it undergoes disintegration and is equal to $1.44 \times L_{1/2}$.

Effective Life (also called *biologic half-life*) is an important clinical concept, since the radioactive isotope deposited in an organ or tissue seldom remains there permanently. A portion of the material is frequently transferred from one part of the body to another or, more important, is excreted. This means that for each radio-isotope, we can think of a biologic half-life that is independent of the physical half-life. For example, the effective half-life may be five days instead of the physical one of ten days. A dose administered would, therefore, be only 50 per cent effective instead of the 100 per cent calculated on the basis of the physical half-life. In I-131 therapy, the effective half-life may vary from 3 to $7\frac{1}{2}$ days. The effective half-life must be evaluated with each isotope in each of its uses in order to achieve accurate dosimetry.

Curie is a term originally derived from radium dosage, but carried over to artificial radio-isotope therapy. A curie of radon in equilibrium with one gram of radium gives off 37 billion particles or disintegrations per second.

1 curie (c) = 3.7×10^{10} disintegrations per second
1 millicurie (mc) = 3.7×10^7 disintegrations per second
1 microcurie (uc) = 3.7×10^4 disintegrations per second

Decay Constant. This is the reciprocal of "average life." The number of atoms disintegrating per unit varies only with the number of atoms present and the *decay constant*. This number is different for each of the different radio-isotopes and is constant for each individual radio-isotope. Formula is:

$$(\text{decay constant}) = \frac{0.693}{L_{1/2}} \text{ or } \frac{1}{L_{av.}}$$

Dosage. In calculating dosage, it is important to realize that a statement concerning the curies or millicuries is a quantitative comment about the number of particles disintegrating per unit time. It does not in itself give the energy given off and absorbed by this quantity. Among the ways of defining this energy, the r unit, because of its common use in roentgen radiation therapy is popularly used. In these calculations a unit known as *rep* (roentgen equivalent physical) is employed. To calculate the *rep*, the energy given off by the alpha, beta, or gamma rays of each radio-isotope must be known.

Since the energy of beta rays goes from 0 to a peak, the average energy ($E_{av.}$) must be used. Alpha ray energy from any one radio-isotope emitter is relatively constant and the maximum energy, $E_{max.}$, is used.

Gamma rays are also measured with $E_{max.}$ Because of the not uncommon emission of multiple photons of different energies from any one radio-isotope, and also because of the range of the gamma rays and their possible escape from the body, measurement is difficult.

CLINICAL APPLICATION

IN DIAGNOSIS and treatment, three isotopes have found common clinical application at the present time. I-131 ($L_{1/2} = 8.0$ days) is the most commonly utilized radio-isotope, principally in thyroid diagnosis and treatment.

Radio-iodinated human serum albumin and fluorescein are also used as tracers in tumor diagnosis. Phosphorus 32 ($L\frac{1}{2} = 14.5$ days) is used in the treatment of polycythemia vera and chronic myelogenous leukemia. Gold 198 ($L\frac{1}{2} = 2.8$ days) is employed in the treatment of pleural effusion and ascites due to tumor metastases. Technics are also being worked out for local infiltration of Gold 198 into tumors such as prostatic carcinoma.

For office use, iodine 131 is of primary value, although phosphorus 32 can also be utilized, since handling and technics are relatively simple.

IODINE 131

IODINE 131 has an ever increasing potential

as a part of a battery of tests to evaluate thyroid function. Tests such as the B. M. R. or blood bound iodine measurements reflect the consequences of accelerated thyroid function. I-131 measures the degree of iodine uptake and helps evaluate the initial processes in the formation of the thyroid hormone. Particular fields of usefulness are in the evaluation of elevated B.M.R. associated with alcoholism, anxiety, compensated hypertensive heart disease, Parkinsonism, and factitial hyperthyroidism (malingering).

Other fields of usefulness include diagnosis and mapping of substernal thyroid and the presence of ectopic functioning thyroid tissue.

Depending on the equipment and the technics utilized, 10 to 50 microcuries of I-131 are administered by mouth and measurements are taken at 24 and 48 hours.

One, two, or more measurements are taken at various intervals, corrected for decay.* Results are given as per cent uptake. For example, a test dose may give 1,000 counts per minute under standard conditions. This is administered to the patient who returns in 24 hours for the first count. Normally the I-131 would disintegrate, so that only 917 counts would be recorded under standard conditions at the 24 hour level. If the thyroid count at

24 hours shows 600 counts, the gland has concentrated approximately 66 per cent of the iodine. Tests at 48 and 72 hours usually show somewhat lower percentages due to continuous excretion of the I-131.

When the technics were first developed, urine accumulation studies were commonly used. That meant that all the urine put out in 24 hours would be counted, and a figure arrived at estimating the amount excreted in the urine. All the rest, except for a few per cent, could be expected to concentrate in the thyroid gland. Any discrepancy would indicate either faulty technic or an ectopic functioning thyroid focus. In practice, office and many hospital technics disregard urine excretion determinations unless a discrepancy is discovered or a specific clinical indication exists. The urine determinations are complicated by the difficulty of ensuring a true 24 hour specimen.

The I-131 uptake tests may be erroneous on biologic or physical grounds. Among biologic sources of error are: kidney disease, heart failure, and edema; previous medication — “antithyroid” compounds like Thiouracil®, Lugol’s Solution, Potassium Iodide; diagnostic drugs—Lipiodol®, gall bladder dyes, intravenous pyelogram dyes; previous diet — iodized salt, seafood, rutabaga, cabbage, strawberries, peas, raw carrots, celery, spinach or milk (actually foods have negligible effect). Middle age uptake is normally twice that of aged. Female’s uptake 1.5 times greater than male’s.

Among the physical sources of error are: erroneous basic technics, improper calibration, extra-thyroidal radio-iodine and background variation.

Results: Carrier-free (all iodine present is radioactive) radio-iodine should be used. The results are not reported as indicating thyroid dysfunction. Instead, a report is given of the percentage uptake. The finding must be evaluated by the clinician in context with other laboratory and clinical findings.

Studies of large numbers of I-131 tracer results indicate a euthyroid range of 9 to 55 per cent with an average of 20 to 25 per cent. The hyperthyroid range is from 22 to 85 per cent with an average of 55 to 71. Among hy-

*The half-life of I-131 is eight days. That means that a given quantity of I-131 disintegrates, so that one half the original quantity is present at each eight-day period. The daily loss in activity is such that 91.7 per cent of the original amount remains after each 24 hour period.

perthyroid patients about 94 out of every hundred will take up more than 35 per cent. Most euthyroid patients tested take up less than 35 per cent.

A popular line of demarcation is 40 per cent.

Instead of measuring the amount of I-131 taken up by the thyroid, some investigators appraise the rate of uptake of I-131 by the thyroid. The tests are more complicated and tedious than the total uptake studies but appear to be more sensitive and may be of value in the study of cases with kidney disease or heart failure.

The therapeutic use of I-131 requires more background and training than that necessary to use it for diagnosis. Principal indications are in the treatment of diffuse thyroid enlargement associated with hyperthyroidism, and in the treatment of thyroid cancer and its metastases.

Perhaps the greatest field of usefulness of I-131 therapeutically is Graves' disease. An attempt should be made to estimate the weight of the gland. A dose of about 8,000 roentgens equivalent (physical) is frequently administered. The average dose will vary between 5 and 11 millicuries. Graphs and nomograms are available for the calculation of dosage which should be based on clinical considerations rather than an arbitrary amount of I-131. In many centers, the treatment of choice in Graves' disease is I-131.

Results are usually seen 3 to 6 weeks after administration of the I-131 with reduction or disappearance of toxic symptoms. Eye signs may remain stationary but frequently improve. Exophthalmus is seldom benefitted. Blood protein-bound iodine decreases. Occasionally toxicity increases a few days following I-131 administration which lasts 24 to 48 hours. It may be caused by increased protein-bound iodine, radiation sickness, or both.

Toxic nodular goitre is still treated by surgery because of the high (10 per cent) incidence of carcinoma. Although there is insufficient follow-up time, there does not appear to be any theoretical or actual evidence of thyroid

cancer resulting from therapeutic I-131 administration.

The treatment of thyroid cancer is not satisfactory since the anaplastic cells in the primary tumor and metastases do not take up enough I-131 to achieve a therapeutic effect. However, various technics are being utilized to increase the uptake and, in some instances, worthwhile palliation is achieved.

Cost of equipment varies with the type of installation desired. It may be procured for a minimum of about \$750 at the present time.

The promiscuous procurement of I-131 facilities will result in abuse of the modality and the possibility of "pushing" the procedures on patients who actually do not require them. Before office use is attempted, careful consideration of volume of work, necessary background and training, financial outlay, as well as the moral and ethical considerations involved should be thoroughly surveyed.

PHOSPHORUS 32

WHEN P-32 was first introduced, a great deal of optimism was expressed about its use in lymphomas and leukemias. In practice, it was found that the lymphomas such as Hodgkin's disease and lymphosarcoma do not respond well to P-32. The response of myelogenous leukemia was somewhat, but not much, better than that achieved with general body x-ray radiation. Some authors, however, prefer to use the Phosphorus 32 because of its added convenience, reserving radiation therapy for the splenomegaly and enlarged nodes. Lymphatic leukemia does not respond as well to P-32 therapy as it does to radiation therapy. P-32 has shown its best results in the treatment of polycythemia vera. Here the ease of administration and efficiency of the treatment make it the preferred modality for this relatively rare condition. Since P-32 is a pure beta ray emitter, there is no reason why satisfactory safeguards cannot be set up so that, when necessary, it can be administered in the office.

GOLD 198 should not be used in office practice. This short life (2.8 days) radio-isotope has relatively limited indications in the serious complications of malignant disease. Some palliation has been achieved in the treatment of fluid accumulations from serous surfaces invaded by carcinoma. Final evaluation of the value of this therapy remains for future appraisal. Radioactive gold can be injected into various tumor masses but this is a complicated procedure due to the steps necessary to ensure proper protection. In addition, the effectiveness of these measures in eradicating tumor masses still requires substantial clinical verification.

RADIO-ISOTOPES have shown definite value in the diagnosis and treatment of certain diseases. Current technics permit the use of certain of these isotopes in the office following prior authorization. Preliminary training must be approved by the Isotope Division of the Atomic Energy Commission. In actual practice, Iodine 131 has been shown to be the isotope of most practical value for office use up to the present time. In the opinion of many authorities, radio-iodine uptake tracer technics are much more accurate than the B. M. R. in determining thyroid function. The treatment of choice for uncomplicated hyperthyroidism is radio-iodine. Phosphorus 32 has definite, but limited, value in the treatment of certain blood dyscrasias.

31 Lincoln Park

Round-up on Chlorpromazine

The medical literature recently has had many articles on chlorpromazine (tradenamed by Smith, Kline and French, as "Thorazine"). Thus, M. S. Sadove, *et al.*¹ have reported that cancer patients were made more comfortable with smaller doses of narcotics or with less potent narcotics by the concurrent use of chlorpromazine. Robinson and Zuck² found it helpful in status asthmaticus, giving the drug intravenously. Friend and Cummins³ reported that 200 milligrams of chlorpromazine a day brought about relief from the nausea and vomiting due to uremia. Radiation sickness and post-x-ray nausea and vomiting were, in most subjects, effectively controlled by chlorpromazine, according to a case reported by Marks⁴ and by Chinn and Sheldon.⁵ Lehmann and Hanrahan⁶ found it uniquely valuable in the control of excitement, while Winkelman⁷ said that "it was remarkable in that it can reduce anxiety, quiet agitated patients and diminish obsessions." Benaron *et al.*⁸ found it serviceable in controlling the vomiting of pregnancy. Moyer *et al.*⁹ used it with success in the control of hiccoughs.

1. Sadove, M. S. *et al.*: Journal of the American Medical Association, 155:626 (1954)
2. Robinson, K. C. and Zuck, Daniel: Lancet, 1:1349 (1954)
3. Friend, D. G. and Cummins, J. F.: New England Journal of Medicine, 250:997 (1954)
4. Marks, Jonathan: New England Journal of Medicine, 250:1000 (1954)
5. Chinn, H. I. and Sheldon, G. L.: Proceedings of the Society for Experimental Biology and Medicine, 86:293 (1954)
6. Lehmann, H. E. and Hanrahan, G. E.: Archives of Neurology and Psychiatry, 71:227 (1954)
7. Winkelman, N. W., Jr.: Journal of the American Medical Association, 155:18 (1954)
8. Benaron, H. B. *et al.*: Exhibit at the June 1954 AMA Convention in San Francisco.
9. Moyer, J. H. *et al.*: Exhibit at the June 1954 AMA Convention in San Francisco.

MERTON L. GRISWOLD, JR., M.D.
Plainfield

A Program for the Burn Patient*

In a 2 year period at the Muhlenberg Hospital in Plainfield, 67 patients with burns were treated. Half of these suffered some full thickness skin loss. Grafting procedures were necessary in 30 cases. Mortality rate was 3 per cent. What was done, and how and why it was done, are clearly explained.

NEW JERSEY, with its concentration of industry and population, faces the problem of mass burn casualties if atomic weapons are used in these areas. Experience in this type of warfare indicates that the thermal burn is still a major problem. Anyone who treats the burned patient knows how time consuming the care of one patient can be.

In this study the treatment of a group of burn patients in one institution is evaluated. The therapeutic plan was fairly uniform in its execution and deals with patients from both the private and general surgical services. From this data we hope to obtain guidance to aid us in setting up a mass burn casualty program which will conserve time and manpower.

The treatment of burns in general has passed through many phases. It is still inescapably true, as Wallace¹ has pointed out, that no single local treatment is ideal for every case. That we have made some progress through the years is brought out by Farmer,² who has given us an interesting analysis of the trend in burn mortality in Canada.

The practitioner who first sees the patient must decide whether the burn is of a degree

which requires hospitalization. A fairly workable rule cited by Wallace³ is to hospitalize any patient who has more than 5 per cent surface burn, who has face and neck burns or who has a deep burn of any size. The "Rules of Nine" (Fig. 1) provide a sufficiently accurate method for calculating the amount of surface burn involved.

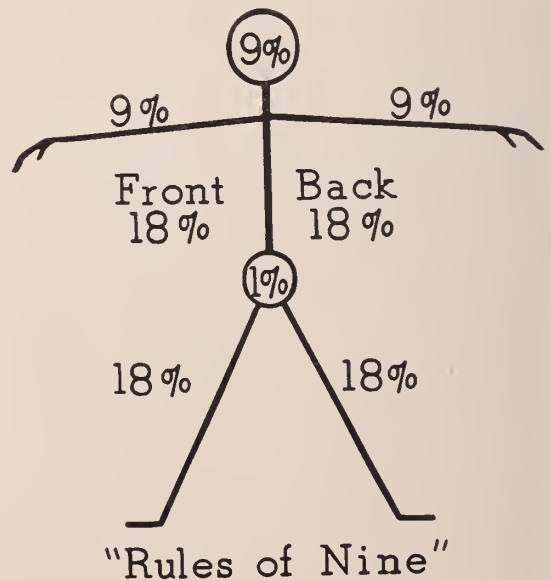


Fig. 1. "Rules of Nine" for measuring burn surface area.

*Read at the staff meeting of the Muhlenberg Hospital, Plainfield, N. J., on January 12, 1954.

For the control of pain, Allen⁴ is cautious about morphine. If the patient is in any stage of shock, capillary absorption is unreliable. Morphine should not be administered subcutaneously but can be given intravenously. Its depressing effects will then not be cumulative with consequent later overdosage.

If the patient is to be transported some clean protective covering such as gauze or ordinary clean sheeting should be used. The aim of this primary or first aid dressing is to prevent additional bacterial contamination. Any dressing involving the application of grease or ointment is better left to the discretion of the physician responsible for the long term care.

On arrival at the hospital, it must first be determined whether shock therapy should be administered. No patient is safe from the dangers of shock until 48 hours have elapsed. Replacement of electrolytes and fluids is a medical problem which has been quite well standardized. In this study, I will omit this phase and concentrate on treatment of the burn wound.

DRESSINGS

THE use of no dressing at all or the "open method" or "exposure" seems desirable at the onset. It eliminates the cost of wound dressings which is important when we have many patients to deal with. The theory that pressure dressings prevent loss of serum has not been a practical consideration. If they are used, emphasis should be placed on their absorptive capacity rather than their ability to produce pressure. Pressure dressings which do not allow for increasing edema should not be used. I have had some near catastrophies due to circulatory constriction. Wallace³ says that edema becomes very marked with pressure dressings and stresses the importance of elevation to encourage drainage from the injured limb early in treatment.

Crassweller⁵ *et al.* studied the actual pressure exerted by the occlusive type of dressing. They concluded that it amounted to no more than 20 to 40 centimeters of water. They also

found that the pressure fell rapidly after the first few hours.

I agree with Martin and Evans⁶ that exposure treatment does *not* work well when the burn extends entirely around the body. Wet, macerated and infected wounds on those surfaces in contact with the body may then ensue. For circumferential burns of the limbs, especially in children, the type of suspension illustrated in Fig. 2 works well.



Fig. 2. A simple method of suspending the leg with stockinette and an elastic bandage. The leg dressing may be readily changed and popliteal contractures are counteracted.

The ultimate aim of treatment is to promote early separation of the devitalized tissues and thus control the inevitable infection which is the real bugbear in the later stages of burn therapy. The open method gives us the opportunity to observe the burn area and determine how much full thickness loss we have. It would be of great assistance if we had any completely satisfactory method for the early determination of the depth of skin loss. Jackson⁷ has investigated methods for diagnosing depth in the fresh burn. He notes that clinical observation plus pain sensitivity (as determined by pricking with a pin) are the most reliable early methods so far proposed.

As soon as we are certain that a full thickness skin loss is present we believe that the complete demarcation of the necrotic skin is hastened by the use of wet dressings applied continuously. Sterile saline soaked hand towels enclosed in waterproof material (such as pliofilm) serve the purpose well. This also

makes the patient comfortable. The towels can be re-used after cleaning and are changed daily by the nursing staff. With each change of the wet towel some of the eschar comes away. Thus, we spare the patient an operative removal of the eschar with its attendant anesthetic. Blood loss and operative trauma are eliminated in a patient who has already withstood a considerable assault by the burn itself. Loose portions of the eschar can be debrided from time to time at the patient's bedside. Tub baths may be administered in conjunction with the wet dressings. The baths are tolerated well and they encourage movement of the parts affected.

I have tried various commercial preparations which act as proteolytic enzymes. They are expensive, often painful and have performed no better than the wet dressings.

Morley⁸ describes how McIndoe, during World War II, developed the "Saline Bath Treatment of Burns." Patients were placed daily in a bath of continuous flowing physiologic saline at a constant temperature for one hour. He considered this method to be highly successful but it involved special facilities. This method is sound in principle, but I use a wetting agent in the form of Gamophen® in the bath itself. McIndoe used tulle gras dusted with sulfanilamide powder as a dressing after removal from the bath and then allowed them to soak off the following day. I prefer re-application of the wet dressings and find that a cleaner, granulating surface results if a local, wide spectrum antibiotic, such as chlortetracycline is substituted for saline after a few days. The chlortetracycline solution is made up to a strength of a milligram per cubic centimeter of distilled water. It is not expensive and combats the infection with less frequent dressing changes.

Blocker⁹ has recommended Neomycin® locally. This he believes, is particularly effective for the Gram negative organisms such as *Proteus Vulgaris* or *Pseudomonas Aeruginosa*.

With the early application of wet, macerating dressings we have been able to advance the removal of slough so that we can graft at some date between the 11th and 16th post-burn day.

Exception to this rule would be a full thickness burn involving not more than 8 per cent of the total body surface. Wells¹⁰ in 1929 recommended immediate excision of the burned area and simultaneous grafting. This principle works well on an extremity, where, for instance, the burn is caused by hot metal. The patient is spared the debilitation and infection while waiting out the period of demarcation and late skin resurfacing.

The following two case reports delineate the general plan of therapy.

CASE REPORTS

1. An 8-year old boy, received full thickness skin burns of the lower extremities on August 23, while heating automobile anti-freeze fluid in a closed container. It was calculated that this was about a 12 per cent body surface burn. For the first 3 days massive soaks with saline immersed towels were applied to the extremities continuously with the right leg, which had the greater skin loss, suspended by a stockinette traction applied to the foot. (Fig. 2.) On the 4th day, chlortetracycline solution was substituted for the saline. On the 8th post-burn day it was possible to remove considerable areas of eschar without anesthesia at the bedside. The wound was covered with a thick split graft on the 11th post-burn day. Then 128 square inches of skin, 12/1000 inches thick were removed with a Reese dermatome from the abdomen. The graft, with its fiberglass backing, was fitted to the raw areas and held in place with one-half inch strips of elastic adhesive which had been previously autoclaved. No stitches were used and the operative time elapsed was 50 minutes.

The grafts were then sealed with a thick gauze roll soaked in chlortetracycline solution. A plicofilm sheet was wrapped around the entire grafted surface.

The dressings were removed on the 4th post-operative day and a 97 per cent take was recorded. Further fringe areas were grafted eight days following the first graft with an operating time of 22 minutes.

The patient was discharged (Fig. 3) from the hospital on Sept. 20 with all areas healed, 28 days after admission.

2. A 30-year old woman sustained burns of face, dorsum of hands and outer right leg from explosion of gas seepage. She was 3 months pregnant at the time of the blast. On admission, 2 units of plasma were given. The hematocrit, 12 hours later was 58 and the R. B. C. was 5,620,000. On the second post-burn day, her output dropped to 1000 cc. despite an intake of 2800. All intravenous therapy was stopped and output went up to 2800 cc. on the third post-burn day. The hematocrit came down to 41 and on the eleventh post-burn day it had dropped to 36 which indicated a relative anemia.

With the use of wet towels changed daily the

slough separated (Fig. 4a and 4b) and split grafts were applied to the dorsum of the hands and portions of the right leg on the thirteenth post-burn day. Operating time for the hand and leg grafts was 86 minutes. No sutures were used and the grafts were fixed (Fig. 5) with elastoplast strips and a gauze head roll. Fine mesh Vaseline® gauze was used on the donor areas. Dressings were removed on the 4th post-operative day and tub baths instituted. Patient was discharged on the 27th post-burn day with all areas healed (Fig. 6a and 6b).

There was no interruption of the pregnancy.



Fig. 3. A complete circumferential burn of the leg showing the status of the grafts after complete healing.

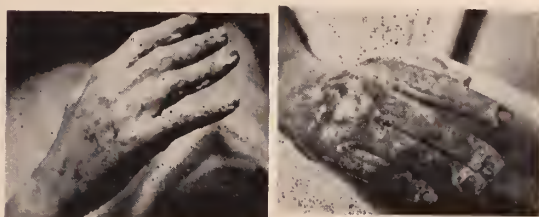


Fig. 4a and 4b. The hand described in Case 2 after removal of slough and just previous to grafting.

IN THE second case, the operating time of 86 minutes was taken up chiefly in applying grafts to the fingers. This is a tedious process because all slough must be removed down to the tendons if free finger movement is to result after healing. Tailoring the skin to the fingers and to the metatarso-phalangeal prominences is very time consuming.

Homografts were used on only one case.

Here there was a 36 per cent surface burn of a 2½ year old boy. The father was the donor and approximately 56 square inches were removed. The homografts registered a 100 per cent take and lasted from 27 to 35 days when they underwent lysis and were replaced by autografts. They did provide a breathing period. There was some rise in the temperature curve when they came away. Whether their use is justified is problematical.



Fig. 5. Method of applying skin grafts to dorsum of hands with strips of elastoplast. Note partial thickness skin loss proximal to wrist which has epithelialized before grafts were placed.



Fig. 6a and 6b. Showing the status of the hand shown in Fig. 4a and 4b after removal of the fiberglass backing and elastic adhesive strips.

In one case, a graft was done after the skin had been allowed to remain unhealed for 157 days. The necessity for early skin resurfacing in major burn wounds should be emphasized. The penalties of delayed grafting are patient debilitation and scar contracture formation which necessitate prolonged, costly rehabilitation procedures.

The figure of 23.3 days in our series represents the time between the burn and the first skin graft. This could be materially re-

duced by promoting the suspicion that if any wound is unhealed beyond the 10th day, the patient is a probable candidate for graft procedures.

Tables 3 and 4 show an apparent rise in the mortality from the Birmingham Unit.¹² However, the mortality rise is coupled with a very marked increase year by year in the incidence of deep burns.

In reference to Rush's Korean figures,¹¹ it would be of interest to know if these burns were under the management of a single unit from the date of burn to the time of complete healing. He reports that out of 275 patients, the incidence of burned surface averaged 27 per cent with only 2 deaths. In general, the percentage of surface burn is an important factor, but it varies with the observer. I do not include erythematous areas but do include areas which had blister formation. A second factor is age. The older patient has a poor survival rate. Moyer¹⁴ says that a mortality rate of 5 to 8 per cent is considered good today.

No figures have been published from the Hospital for Sick Children in Toronto since 1943, but Farmer¹⁵ doubts if there has been any significant drop from the 3 per cent figure.

Few writers have reported on "mean healing time." This is a somewhat empirical definition but we have used Jackson's¹² interpretation of the "healing time" as the days intervening between injury and complete epithelialization. The latter term includes separation of all scabs.

TABLE 1.
BURN MORTALITY (Canada)²

	Per Cent
1913-1924 Average Mortality	35.2
1925-1928 Average Mortality	16.1†
1929-1937 Average Mortality	11.8
1938-1941 Average Mortality	2.9†

†Tannic acid spray and blood transfusion therapy were instituted during the 1925 to 1928 period. The sulfa drug era began in 1938.

TABLE 2.

SUMMARY OF IN-PATIENT BURNS

Total In-Patient Burns 1952 and 1953	67
Number of Deaths	2
Mortality	3%

Mortality Breakdown:

Male, Age 89 yrs.	
Percentage burn: 18%, Hospital Stay—14 days	
Male, Age 82 yrs.	
Percentage burn: 36%, Hospital Stay—11 days	
(No grafting was done on patients who died)	

Number of Patients with Partial Thickness Skin Loss	35
Number of Patients with Full Thickness Skin Loss	32
Percentage of Burn In Patients with Full Thickness Loss, 1 to 9%	15
10 to 27%	15
28 to 36%	2
Average Percentage Burn	12%
Average Days in Hospital Grafted Patients	29.3
Average Days Hospital from Adm. to First Grafting Procedure	11.0
Average Days from Date of Burn to First Grafting Procedure	23.3
Full Thickness Burns. Males 24. Females	8
Average Age of Full Thickness Burns (yrs.)	22.3
Children (1 to 12 yrs)	18
Adults	14

Grafting Procedures per Patient

(One Grafting Procedure)	18
(Two Grafting Procedures)	10
(Three Grafting Procedures)	1
(Four Grafting Procedures)	1

TABLE 3.

MORTALITY FIGURES

Author	Years Covered	Mortality
Farmer ²	1941	3.0%
Rush ¹¹	1953	0.7%
Jackson ¹²	1948	3.0%
Jackson ¹²	1949	4.0%
Jackson ¹²	1950	5.0%
Jackson ¹²	1951	7.0%
Pemrick and Musselman ¹³	1953	9.0%
Griswold*	1953	3.0%

Note: Dr. Rush's study¹¹ is a report from the military front in Korea.

*Refers to the study here reported.

TABLE 4.

INCIDENCE AND HEALING OF "FULL THICKNESS" BURNS

Year	Patients with "Full Thickness" Burns, Percentage	Healing Time of these Burns, in days
1948, Jackson ¹²	59	44
1949, Jackson ¹²	68	50
1950, Jackson ¹²	76	55
1951, Jackson ¹²	88	55
1952, Griswold	51	49
1953, Griswold	50	32

TABLE 5.

HOSPITAL STAY OF "GRAFTED" PATIENTS

Pemrick and Musselman ¹³	59 days
Griswold (this report)	29 days

947 Park Avenue

SUMMARY

CONSIDERATION has been given to the problems encountered in the management of a small series of major burn wounds. An attempt has been made to simplify and standardize, within limits, burn treatment procedures for a larger number of burn casualties. Reports from other sources have been evaluated. The best results in burn therapy are probably obtained in institutions where the personnel are familiar with the problems likely to be encountered and where facilities are available for the earliest possible rehabilitation of these unhappy victims of the thermal burn.

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New Oral Prescription Law

Treasury Department's Bureau of Narcotics, which is expected to administer the new oral prescription law (Public Law 729), is working on regulations preparatory to consultation with drug manufacturers, pharmacists, and American Medical Association on what drugs to place on the exempt list. This list will name all narcotic drugs having little or no addiction liability that may be prescribed by tele-

phone. Meanwhile, the Bureau reminds physicians that the *federal law does not supersede state laws* barring oral prescriptions. Virtually all states forbid oral prescribing. With a majority of state legislatures meeting this coming year, interested groups will be making a strong effort to get state laws changed to conform with the more liberal new U. S. law.

HARVEY E. NUSSBAUM, M.D.

Newark

Use of Diamox* to Potentiate the Action of Mercurial Diuretics

When mercurial diuretics are unsuccessful in congestive heart failure, they may be effectively potentiated by the administration of a carbonic-anhydrase inhibitor here described.

SINCE the introduction of mercurial diuretics in congestive heart failure by Vogl,¹ there has been a constant search for less toxic, if not more effective, medication. Mercurial diuretics relieve edema in congestive failure. But an occasional patient becomes refractory to them, if only temporarily. Up to now, additional methods of increasing the efficiency of the mercurial diuretics, such as acidification and increasing the dosage, have been disappointing, except where a distinct electrolytic imbalance can be demonstrated.

Soon after the introduction of sulfanilamide, it had been observed that this drug produced an incidental renal loss of sodium, potassium and water.² Further investigations³ revealed that most sulfonamides were carbonic anhydrase inhibitors. In 1949, it was shown that sulfanilamide could produce diuresis in patients with congestive heart failure.⁴ In the search for less toxic compounds, Diamox,* a 2-acetylamino-1,3,4 thiadiazole-5-sulfonamide, was found to produce renal loss of Na⁺, K⁺, HCO₃⁻, and water. This it apparently did by inhibiting the action carbonic anhydrase in the tubules. Most recently,⁵ it was found to be clinically effective⁶ in congestive

heart failure.⁷ The following cases further illustrate its use together with mercurial diuretics in congestive failure, where mercurial diuretics alone seemed to have become ineffective.

CASE ONE

A 59-year old white male with rheumatic heart disease had been suffering from congestive heart failure for several years. When first seen, he complained of marked dyspnea, orthopnea and edema of the legs. The heart was massively enlarged. There

*Diamox is the trademark of Lederle Laboratories Division of the American Cyanamid Company for acetazoleamide or 2-acetylamino-1, 3, 4-thiadiazole-5-sulfonamide.

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were valvular lesions of aortic insufficiency, mitral stenosis and insufficiency. He had auricular fibrillation and intraventricular conduction defect. The liver edge was palpable four finger-breadths below the right costal margin. The spleen was palpably enlarged. There were ascites and bilateral pleural effusion. There was 4-plus pitting edema of the legs. The patient had been on Mercuhydrin† almost daily alternating with additional Neohydrin†. He was maintained on digitoxin 0.2 milligrams daily, and a salt-free diet. Twenty-four hours' urinary output finally would not exceed 10 ounces on this regimen. Diamox® was given in dosage of 250 milligrams, three times a day. In 48 hours an injection of Mercuhydrin®, 2 cc., produced a diuresis of 110 ounces. There was, subsequently, marked clinical improvement. The patient was maintained, thereafter, on 250 milligrams, three times a day for 5 days each week with a bi-weekly injection of Mercuhydrin®. For the next four months he was mostly ambulatory, although not able to pursue his occupation. He suddenly expired with the picture of cerebral embolism.

CASE TWO

A 35-year old white female with chronic rheumatic heart disease, was first seen September 23, 1953. She then had marked ascites and pleural effusion, and valvular lesions typical of mitral stenosis, mitral insufficiency and aortic insufficiency. There was massive cardiac enlargement and hepatomegaly, besides dependent edema. The blood count was normal. The urea nitrogen was 21.0 mg. per cent, creatinine 1.2 mg. per cent, sodium 139 mE/L, potassium 3.7 mE/L, and chlorides 105.5 mE/L. The electrocardiogram revealed auricular fibrillation with ventricular premature beats. The patient was receiving digitalis and observing a salt-free regimen. She had been treated by her family physician to a point where she was receiving three injections of Mercuhydrin® weekly without any noticeable diuretic effect. Mercuhydrin® 2 cc., and 1000 milligrams of Diamox® daily for three days did not cause any change in the clinical picture. Her weight remained unchanged. At abdominal paracentesis, six quarts of fluid were obtained. Then there was a 13-pound weight loss which was then maintained with only a 3-pound weight gain. There was loss of peripheral edema. A second paracentesis in ten days resulted in a further loss of 7 and one-half pounds and with marked clinical improvement. She became ambulatory and maintained the weight loss with no re-accumulation of ascites and almost complete disappearance of the pleural effusion. This improvement continued until discharge two weeks later, in spite of the patient being actively ambulatory.

The patient was subsequently followed at weekly intervals as an outpatient, and the improvement was maintained on a regimen of Diamox® 250 milligrams three times a day, plus 2 cubic centimeters of Mercuhydrin® weekly.

†Mercuhydrin is the trade name for sodium meralluride, manufactured by Lakeside Laboratories, Milwaukee, Wisconsin. Neohydrin is the same company's trade name for 3-chloromercuri-2-methoxy-propylurea.

CASE THREE

A 66-year old white female with arteriosclerotic heart disease and auricular fibrillation had had several previous admissions with congestive failure. On this admission, there was very marked dyspnea, edema, and anxiety. She no longer experienced good result from Mercuhydrin®. In spite of daily injections for two weeks, her weight did not change. A change to an oral mercurial diuretic resulted in a weight gain of 3 pounds. There was a consequent increase in dyspnea and edema. A return then to injectable mercurial resulted in a weight loss of 8 pounds. There was a clinical improvement, but still troublesome dyspnea. Diamox® at this point in dose of 250 milligrams three times daily resulted in a marked increase in urinary output. The psychologic effect alone was tremendous. Single voiding of as much as 12 ounces was recorded. The sedative effect of the drug made it possible for her for the first time to sleep for long intervals. The patient became ambulatory, lost her edema and dyspnea. She was able to make a trip out west to live with a niece and two months later was sufficiently well on a maintenance dose of daily Diamox® and bi-weekly Mercuhydrin®, to seek employment.

CASE FOUR

A 57-year old white male with arteriosclerotic heart disease, had had a posterior myocardial infarction some months before. There was now a partial A-V block. The liver was two fingers below the right costal margin and tender. He had marked left ventricular enlargement. His chief difficulty was dyspnea, especially nocturnal paroxysmal dyspnea. He reported marked discomfort of the upper abdomen and frequent vomiting after meals. After digitalization, mercurial diuretics and bed rest, much of the symptomatology disappeared. However, dyspnea and nocturnal cough persisted. Diamox® was then given three times daily (along with digitoxin and Neohydrin®). There was a weight loss of 12 pounds. The Diamox® was discontinued but weight continued to fall. Neohydrin® was discontinued and a weight gain of 5 pounds was recorded. The patient was placed on a maintenance dose of 250 milligrams of Diamox® daily. Symptomatically, he lost all dyspnea and felt stronger, and walked with a new vigor. The heart size (estimated on fluoroscopy) was smaller. The patient was then continued on Diamox® 250 milligrams daily. More than this produced headache. Neohydrin® one tablet daily was also given. At the present writing, six months later, he has been well enough to accept a position doing clerical work.

CASE FIVE

A 27-year old white female with rheumatic heart disease had a long history of disability from reactivated rheumatic fever and bouts of failure. One year before admission, she accidentally ingested an over-dose of digitalis. This resulted in marked bradycardia and cerebral embolism with hemiplegia. From this she had made an excellent recovery. At the present admission, she complained of joint pains, headache and fever. The heart was tremen-

dously enlarged to the right and left. There was auricular fibrillation with a ventricular rate of 130. The valvular lesion was mitral stenosis and insufficiency and aortic insufficiency. The liver was four fingers below the right costal margin. She had ascites. Blood cultures were negative. For the first few days in the hospital she was fairly comfortable on symptomatic treatment. Suddenly her condition deteriorated and she became moribund in spite of digitalization, mercurial diuretics, salicylates and oxygen. Diamox® was given 250 milligrams three times daily, but for ten days there was no significant change. Then she began showing progressive improvement. In the following six weeks, she again became ambulatory and was discharged for outpatient care. Five months later the patient was still maintaining the improved state, receiving Diamox® 250 milligrams daily and Neohydrin® twice a day.

COMMENT

FIVE patients are presented, suffering from congestive heart failure, who were more or less refractory to mercurial diuretics although fully digitalized and on salt-free diet. Before the use of Diamox®, in cases 1, 2, and 3, this refractory state was absolute; that is, not only was symptomatology not relieved but there also was no demonstrable change in urinary output following an injection of mercurial diuretic. In cases 4 and 5, in spite of an apparently fair response to mercurials, there was marked persistence of severe disability therefrom. The action of Diamox® in case 2 did not become manifest until adequate abdominal paracentesis was performed. In no case except the first was the resulting urinary output spectacularly increased. Yet in all cases, outstanding clinical improvement resulted. In case 4 particularly, there was relief of dyspnea. Patients 1, 2, and 3, were critically ill and were not responding to the usual procedures. Patient 5 was actually moribund when Diamox® was started. The response was not dramatic, but progressive clinical improvement was seen in all cases. This was true whether or not there was immediate

increased diuresis. Since this study was a clinical evaluation, no electrolytic studies were performed. However, Friedberg⁶ found that the rate of sodium excretion increased in all subjects after Diamox®, regardless of the diuretic response. This could in part explain the apparent clinical improvement without necessarily having increased diuresis. In Friedberg's series,⁶ however, the three patients who had no increased diuresis, had no clinical improvement. This is contrary to our experience.

In these severely ill patients, Diamox® alone was insufficient to control the congestive failure. However, after Diamox® was given, the previously experienced non-responsiveness to mercurials was no longer seen. It was apparent that the Diamox® had "potentiated" the mercurial. The greatest urinary output was obtained when the two were used in conjunction.

The dosage of Diamox® in these patients was usually 250 milligrams three times a day. Greater effectiveness was noted when the dosage was interrupted several days a week.

Toxic side reactions were noted in only two patients. In one, the three tablets daily resulted in headache. This disappeared on reducing to one tablet daily (without altering the therapeutic effect). In the other, some drowsiness occurred soon after taking the medication, but not of sufficient severity to be bothersome.

CONCLUSION

A RECENTLY-INTRODUCED, non-mercurial drug called Diamox® is reported. This has diuretic properties by virtue of being a carbonic anhydrase inhibitor. It has been successfully used, together with mercurial diuretics, in patients with congestive failure in whom mercurial diuretics alone were unsuccessful.

695 Clinton Avenue

JANET L. ECKHARDT, M.D.

South Orange

An Oral Penicillin-Antihistamine Combination

Its Value As Prophylaxis for Recurrent Rheumatic Fever and Treatment of Respiratory Infections

Dr. Eckhardt finds that it is generally worthwhile to add an antihistamine to penicillin when using that drug (a) to treat a respiratory infection or (b) to prevent recurrences of rheumatic fever.

PENICILLIN sensitivity has now become an important clinical problem. Indeed, penicillin today "heads the list of medicinal agents in the frequency, diversity, and severity of the sensitivities which it induces." (Kern and Wimberley¹) The rising incidence of penicillin reactions has been noted by Pelner and Waldman² and Zussman.³ Solval⁴ advises careful selection of patients and cautious administration to prevent penicillin reactions. In a recent study of allergic children,⁵ a 10 per cent incidence of penicillin reactions was reported. The same investigators found an overall incidence (allergic and nonallergic children) of 6 per cent penicillin reactions. This corresponds to estimates of 6 to 7 per cent reported by other authorities.^{6,7}

There is a definite relationship between penicillin sensitivity and previous exposure to penicillin. Although the rate of penicillin reactions showed a marked drop with the introduction of penicillin G, it has once again risen as repeated courses of therapy have resulted in sensitization of more and more patients.

Urticaria, lasting for several days to several months, is a frequent manifestation of penicillin sensitivity. Transient rashes, which may be erythematous, punctate, or morbilliform, are common. Serum sickness, marked by urticaria, itching, joint pain and swelling, fever, malaise, and nausea and vomiting, is probably the commonest type of reaction to penicillin.

Investigators⁸⁻¹² have found that antihistamines will prevent or control penicillin sensitivity. The purpose of this study was to determine whether the combination of penicillin and an antihistamine in a single tablet would prevent penicillin reactions and whether this combination possessed the same therapeutic efficiency as plain penicillin.

The preparation used, Penicillin-PBZ®, has recently been made available in two forms: Penicillin-PBZ® 200-50 tablets, each of which contains 200,000 units penicillin G and 50 mg. Pyribenzamine® hydrochloride; and Penicillin-PBZ® 200-25 tablets, each of which contains 25 instead of 50 mg. Pyribenzamine.®

In 1953, forty-three pediatric patients with

rheumatic fever and congenital heart disease received the penicillin-antihistamine tablets as prophylaxis against recurrent active rheumatic fever and other infections. On alternate months, these patients received plain penicillin 200,000 unit tablets. Thirty-five of these cases were followed at the Orange (N. J.) Memorial Hospital clinic and five were seen in private practice.

Four children and one adult, all known to be sensitive to penicillin, were treated with Penicillin-PBZ® 200-50 for tonsillitis or pharyngitis.

RESULTS

OF THE 43 patients with rheumatic heart disease, four felt that they had fewer respiratory infections with the use of Penicillin-PBZ®. The remaining patients in this group noticed no difference between Penicillin-PBZ® and the plain penicillin tablets. (It should be noted that autumn 1953 seemed to be an exceptionally "healthy" one for the children, since fewer complications of respiratory and upper respiratory infections were observed.) No cases of penicillin allergy developed with either the plain penicillin tablets or the penicillin-antihistamine tablets. Penicillin 200,000 unit tablets, with or without Pyribenzamine®, proved to be a good prophylaxis in these cardiac patients. Children who received the tablets containing 50 mg. Pyribenzamine® complained of drowsiness. No side effects of the tablets containing 25 mg. Pyribenzamine® were reported. In the five patients known to be penicillin-sensitive, *not a single reaction developed following administration of Penicillin-PBZ®.*

Case 1 was a child with inactive rheumatic heart disease. He was given Penicillin-PBZ® 200-50 every four hours for 72 hours for acute pharyngitis without any reaction. The previous January, he had been given oral penicillin for a period of 3 to 4

days and developed a fine macular rash with severe itching as a result of therapy.

Cases 2, 3, 4 and 5 were all in one family of children aged 5, 8, and 10, and their mother. The youngest had developed a mild exfoliative dermatitis due to penicillin the previous March. The other patients had experienced a fine red itchy rash and a thick bloated tongue with a previous course of penicillin. In October, the children developed acute tonsillitis and were treated with Penicillin-PBZ® 200-50, one tablet every four hours for 72 hours. They had no toxic symptoms or reactions of any kind. Shortly thereafter, the mother developed pharyngitis and was given the same course of therapy with Penicillin-PBZ®. No rash developed but she did complain of a slightly itchy skin. No tongue symptoms were noted.

In these five cases, Penicillin-PBZ® proved to be as efficient therapeutically as plain penicillin.

CONCLUSIONS

1. Of the 43 rheumatic heart disease patients, four felt that they had fewer respiratory infections with Penicillin-PBZ®. The remaining patients noted no difference between Penicillin-PBZ® and plain penicillin tablets.
2. No cases of penicillin allergy developed with either plain penicillin tablets or Penicillin-PBZ®.
3. Both Penicillin-PBZ® and plain penicillin proved to be effective prophylactic measures in these cardiac patients.
4. Children became drowsy with 50-mg. doses of Pyribenzamine® but no side effects were reported with the use of the tablets containing 25 mg. Pyribenzamine®.
5. Five patients known to be sensitive to penicillin experienced no reactions following administration of Penicillin-PBZ®; this combination seemed to be as efficient therapeutically as plain penicillin.

ACKNOWLEDGMENT

Penicillin-PBZ® was made available through the courtesy of Ciba Pharmaceutical Products, Inc., Summit, New Jersey.

120 Prospect Street

A bibliographic list of twelve citations appears in author's reprints.

LEONARD ZWEIBEL, M.D.

Newark

Foreign Filled Rx May be Hazardous

IN THESE days of easy and frequent foreign travel, it must often happen that a patient carries with him to Europe or South America, a prescription written by a physician here. Because of the difference in metric and apothecary's dosage terms and because of the difference in terminology, this may prove hazardous.

Here is a case in point.

A 51-year old woman was in Europe during the summer of 1954. She airmailed a letter to me reporting some symptoms which, I knew from past experience with her, could be controlled by phenobarbital. I first wrote a prescription for phenobarbital, and then learned that this phrase was not used in continental Europe. They use the proprietary name Luminal®. So I wrote the prescription for one-quarter grain tablets and called for 48 tablets with an instruction to take one three times a day. This, of course, was a harmless prescription.

My patient went to a pharmacy in Madrid and had the prescription filled. After taking one tablet she became dizzy and vomited. A physician in Madrid told her that this was due to something she ate. It was. It was due to the phenobarbital. She had sense enough to discontinue the medication and sense enough to bring back the bottle. There it was, carefully labelled, "Luminal, 0.3 Grams." Apparently they read one-quarter grain as 0.25 Grams and issued a 0.3 Gram tablet as the nearest to it.

A 0.3 Gram tablet contains 5 grains. I had called for one-quarter of a grain. She was getting 20 times as much as I had prescribed!

Moral: If your peripatetic patient needs a prescription while travelling in a non-English speaking country, have the Rx filled here, and send the patient the medication, not the prescription.

871 South Eleventh Street

World War II Leprosy Case Reported

In the Sept. 11 (1954) Journal of the American Medical Association, Dr. N. E. Levan of Bakersfield, California described what appears to be the first reported case of leprosy acquired during World War II military duty.

Dr. Levan said that some cases had been expected in servicemen stationed in regions, such as the Philippines, where leprosy is prevalent. Some instances of the disease may be "anticipated during the next 30 years or more

in veterans of both World War II and the Korean campaign who served" in such region.

Dr. Levan's patient was stationed on Luzon during the war, and was quartered in a native house. There was nothing in his record to indicate his condition could have been contracted outside of military service, Dr. Levan said. The patient is being treated, and he complies with regulations for temporary "modified isolation."

WILLIAM M. SULLIVAN, JR., M.D.

PAUL GROSSBARD, M.D.

Passaic

Supine Hypotensive Syndrome Producing Abruptio Placentae*

Variations of blood pressure with body posture are well known. Less well known is the fact that if a pregnant woman is in the supine position, and then assumes the lithotomy position, this may produce such pressure on the inferior vena cava as to cause premature separation of a well-implanted placenta. An illustrative case is cited.

MANY obstetricians have noticed that certain patients in late pregnancy exhibit a drop in blood pressure on assuming the supine position. Recently Howard, Goodson, and Mengert¹ substantiated previous observations on the supine hypotensive syndrome. In November 1953 Mengert, *et al.*,² reported two cases of induced premature separation of the placenta at the time of cesarean section by manual compression of the inferior vena cava for five minutes. The case reported below confirms this factor in the genesis of abruptio placentae.

A 29-year old pari I, gravida II, had an uneventful pregnancy until the beginning of her ninth month. At that time there was slight elevation of blood pressure and two plus pitting edema of the

legs. One week later blood pressure was 144/90, there was four plus generalized edema, and one plus albuminuria. She was given the usual pre-eclamptic management. In three days her blood pressure returned to normal and her edema and albuminuria disappeared. She was discharged and sent home.

Three days later, she reported a heavier than normal bloody show. On re-admission, examination showed no active bleeding. The uterus was near term in size and soft. Fetal heart rate was 148. Her blood pressure was 118/78, pulse 76. She did not complain of pain or of uterine contractions.

She was taken to the delivery room for a sterile vaginal examination. From the time she was put in lithotomy position until the examiner (P.G.) entered the room, about ten minutes had elapsed. On entering the room, the patient complained of marked weakness. She was sweating profusely and was cold and clammy. Her blood pressure was unobtainable and no pulse could be felt. She was taken out of the lithotomy position, given intravenous Dextran® with Levophed®, and oxygen. Blood pressure gradually returned to 80/60.

While this was being done examination of the uterus showed that it was very tense. Fetal heart rate at this time was over 200 per minute. Preparation was made for immediate cesarean section, and the patient transported to the operating room.

Fetal heart rate was now 60 per minute, and the patient's blood pressure was 90/70. The uterus was of board-like consistency, and the patient complained of constant abdominal pain.

1000 cubic centimeters of whole blood were given under pressure. A cesarean section was performed

*From Passaic General Hospital.

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2. Mengert, W. F., Goodson, J. H., Campbell, R. G. and Hayme, D. M.: Observations of the Pathogenesis of Premature Separation of the Normally Implanted Placenta. *Am. J. Obst. & Gynec.* 66:1104, November, 1953.

with delivery of an 8-pound, 5-ounce living female infant. Upon opening the uterus, 800 cubic centimeters of dark red blood were evacuated. Approximately one-third of the placenta was found detached from the uterine wall and covered with small, fresh clots. No old clots were seen which might have indicated a previous abruption.

COMMENT

THIS case offers clinical proof of what Mengert and his co-workers² have shown experimentally at the time of cesarean section: compression of the inferior vena cava can produce premature separation of a normally im-

planted placenta. The lithotomy position in a potentially susceptible patient, already in a supine position (in bed or on examining table) produces marked pressure on the inferior vena cava resulting in this complication.

CONCLUSION

A case of premature separation of a normally implanted placenta immediately following the supine hypotensive syndrome in late pregnancy is reported. The findings were substantiated at the time of cesarean section.

162 Lexington Avenue

Pointers on Polio

Stimson (Journal of Pediatrics, 44:607, 1954) offers the following practical poliomyelitis pointers:

Usually there is little real danger in leaving a patient with mild polio at home, at least for a time. In fact, there are many good reasons for not removing mild cases to the hospital.

Indications for removing the patient to an adequately equipped hospital include: Increasing temperature rise, marked prostration, difficulty in breathing, swallowing or emptying the bladder, and weakness of the deltoid muscle.

If one deltoid is weak, some weakness of the diaphragm is likely. If both deltoids are weak extensive diaphragmatic weakness and breathing difficulty are almost a certainty.

Acutely ill polio patients are potential heart cases. Over one-half of patients dying in the acute stage show some degree of myocarditis at autopsy.

Maximum communicability occurs during the few days before and after symptoms develop. Patients who live under proper sanitary conditions of sewage disposal can be considered noncontagious 24 hours after the temperature returns to normal.

Viremia occurs during the last few days of the incubation period but does not persist after the first day of fever.

Polio virus is present in the stools of patients and contacts for an indefinite period. If sanitary conditions are good the hazard of spreading the disease during this time is not very great.

Healthy carriers are common. Resistance to poliomyelitis depends upon antibodies. Resistance can be lowered by factors which facilitate introduction of the virus into the body.

An established infection can be increased in severity by excessive fatigue, chilling, pregnancy, respiratory infection, inoculations, cortisone therapy, mental stress and perhaps high atmospheric temperatures.

Symptoms of poliomyelitis include headache, fever, vomiting, stiffness of the neck and back muscles, and occasionally, mild twitching. Quinine is commonly effective in relieving cramps and muscle twitchings that occur during acute polio. The spinal fluid is usually abnormal but there seems to be no relationship between the number of cells present in the fluid and the extent or severity of muscle weakness. The chief diagnostic value of spinal fluid examination is to rule out the presence of septic meningitis.

The most common condition to be mistaken for polio is influenza. Headache, fever, vomiting and general muscular pain are also characteristic of this disease. Hysteria may be a confusing symptom. In such cases, deep reflexes are present and paralysis is likely to involve all muscles used in a given movement, not muscles in various parts of the body. If a patient suspected of having polio can touch his lips to his knee, he probably does not have polio.

The best treatment for a polio patient is natural sleep and lots of rest. Patients with fever should not be awakened, not even for meals. They should be encouraged to relax in mind and body. Artificially induced sleep is dangerous in acute cases because of the possibility of inducing respiratory embarrassment. The acutely ill patient should not be fatigued by unnecessary treatment or examinations.

Psychomotor Epilepsy

Sometimes queer behavior is due neither to hysteria nor to psychosis, but rather to a strange nonconvulsive disorder known as psychomotor epilepsy. It is, in most cases, gratifyingly responsive to treatment.

PSYCHOMOTOR epilepsy is a baffling and bizarre condition. The symptoms and conduct of the patient are frequently mystifying. The patient's complaints at times may sound fantastic. Manifestations of this illness are protean. The electroencephalogram shows abnormal electrical discharges in either one or both temporal lobes.

The physician who has the responsibility of making a diagnosis in these cases will often consider the patient to be either neurotic or psychotic. One study¹ reports on 100 non-institutionalized patients actually suffering from psychomotor epilepsy, whose presenting complaints were interpreted as psychiatric conditions.

Psychomotor epilepsy may be defined as a paroxysmal episode of uncontrollable behavior with associated cerebral dysrhythmia but without convulsive manifestations. These episodes may be accompanied by some impairment of consciousness, and there may or may not be amnesia for the event.

In psychomotor epilepsy some patients exhibit chewing movements or smacking of the lips. They may unconsciously unbutton clothes, laugh or cry for no apparent reason, talk in a confused manner, or even act as if intoxicated. Some report the *déjà vu* phenomenon; others complain of micropsia or macropsia. Some show intense terror without apparent cause, while a few manifest maniacal or assaultive behavior.

Gibbs and Lennox² point out that in psychomotor epilepsy, the electroencephalogram characteristically shows discharges of flat-topped 4-per-second-waves, together with high voltage 6-per-second-waves or, discharges of regular positive spikes appearing in bursts. This abnormal electrical activity is most often noted in the temporal lobes. Lennox³ states that the psychomotor attacks consist of periods of amnesia without convulsive movements other than perhaps some tonic rigidity of the muscles.

Lennox⁴ reported a study of 1900 office patients which revealed that 207 had a history of psychomotor attacks with or without other seizure pattern. A proper approach to this problem demands the cooperative teamwork of the neurophysiologist, the neuropathologist, the neurologist, and the neurosurgeon. The crucial diagnostic procedure is electroencephalography. It is unfortunate that so few physicians adequately use this modern procedure.

1. Mulder, D. W. and Daly, D.: Psychiatric Symptoms Associated with Lesions of Temporal Lobes. *J. A. M. A.* 150:173 (September 20, 1952).

2. Gibbs, F. A., Gibbs, E. L. and Lennox, W. G.: Electroencephalographic Classification of Epileptics. *Arch. Neurol. & Psychiat.* 70:11 (August 1953).

3. Lennox, W. G.: Treatment of Epilepsy. *J.A.M.A.* 134:138 (May 10, 1947).

4. Lennox, W. G.: Correlates of the Psychomotor Triad. *Neurology* 1:357 (September 1951).

The diagnosis once established, results are often most gratifying to both patient and physician.

I have seen a number of patients with severe unremitting headache who had been unsuccessfully treated for from 5 to 25 years, for "migraine" and other conditions. It was astonishing, however, to find in these cases a positive psychomotor pattern, and gratifying to see the relief of the headache which often followed anticonvulsant therapy.

An additional example of possible manifestations of this disease is afforded by a case involving sexual abnormalities, for which the individual was arrested by the police. The electroencephalogram in this instance showed a definite psychomotor pattern. Treated with anticonvulsants and psychotherapy for a year, this patient not only underwent an almost complete change in personality, but during this same period received three promotions on his job. There was, in addition, a better adjustment towards his family and community.

Another example of the sometimes curious manifestations of this condition is that afforded by a man who had broken into a house. When found by the family who lived there, he was sitting on the floor, confused and in tears. Questioning elicited that he had no idea as to the manner of his entry into the house nor of the reason. The electroencephalogram showed a definite psychomotor pattern. The man's record revealed 27 other conflicts with the law.

The potentially important social and legal ramifications of psychomotor attacks are illustrated by one individual who committed murder during a so-called psychomotor attack. He killed a man who was a total stranger to him, and without the slightest motive.

ALTHOUGH this condition is called psychomotor epilepsy, most of the patients do not have convulsive movements of the type commonly conceived of in connection with epilepsy.

Earle, Baldwin and Penfield,⁵ recently made a tremendous contribution toward elucidation of this aspect of the problem. They pointed out

that epileptogenic discharges in the temporal cortex produce a variety of seizure phenomena, among them: abdominal aura, cephalic aura, olfactory aura, psychic hallucinations, dream states, illusions of perception (e.g., *déjà vu* phenomena), and automatism. In 157 cases, surgical exploration revealed 100 (approximately 63 per cent) in which findings were suggestive of compression or anoxia during birth or infancy as the causative factors. The remaining 57 patients had cerebral evidences of postnatal injury, intracranial infection, or neoplasm in the temporal region.

Gross and microscopic abnormalities were found in *all* cases of this series. Gross lesions varied from atrophy or toughness of a single gyrus to atrophy of an entire temporal lobe and parts of the adjacent cortex. The gyri were often shrunken, yellow, avascular, and obviously smaller than normal. The abnormality most commonly found was a sclerotic area of cortex in inferior or medial parts of the temporal lobes. The uncus, hippocampal gyrus, and part of the first temporal gyrus were usually involved.

The temporal lobe was found⁵ to be particularly susceptible to anoxic states, and to birth injuries with resultant mechanical interference with the blood supply. Penfield *et al.*⁵ pointedly reaffirmed Spielmeier's observation that the temporal lobes are especially liable to damage by anoxia. They also emphasized the importance of the fact that the arteries supplying the mesial and inferior surfaces of the temporal lobe cross the free margin of the tentorium. Thus, herniation of the temporal lobe through the incisura of the tentorium, if it occurs at the time of birth, can readily produce ischemia of the herniated uncus and the hippocampal gyrus. A further result may be compression of the arteries and veins, particularly the anterior choroidal and branches of the posterior cerebral artery, supplying the inferior surface of the temporal lobe.

The following brief reports of some cases seen in practice, are illustrative of the scope of psychomotor epilepsy:

5. Earle, K. M., Penfield, W. and Baldwin, M.: Seizures Produced by Hippocampal Herniation. *Arch. Neurol. & Psychiat.* 69:27 (January, 1953).

CASE ONE

A girl of 14 stated that whenever she was called on to recite in class, her vision became blurred, and her words became so garbled that she had difficulty in speaking. This condition lasted for about an hour and was followed by a severe generalized headache and associated earache. She said that whenever she had such an attack people seemed to be "far away," and the environment seemed dreamy in character. At the beginning of these attacks, the people in the environment seemed to spin around and then fade away.

An electroencephalogram showed a psychomotor pattern. She was treated with anticonvulsants and thereafter experienced complete remission of her attacks for an observed period of several years.

CASE TWO

A man was referred in August 1950, following a charge of indecent sexual exposure. The patient's wife was in her eighth month of pregnancy. Because of this, the defendant said he had felt strong erotic desires which were not consummated. He explained that they had rarely had sexual relations during her pregnancy because of his feeling that if he attempted them, his wife "might lose her life." He amplified his statement by saying that he lost his buddy in the war, and felt he could not stand the strain imposed by the death of someone for whom he cared. He emphasized that prior sexual relations with his wife had been very satisfactory.

He complained of having been "nervous" and "jittery" since release from military service in 1946. He had had combat duty in the Pacific. He felt embarrassed because of his unreasonable irritability towards his wife, child, and mother. He had been attending school during the day and working at night.

The wife stated that her husband had recently been having "peculiar spells" during which he seemed confused, disoriented, went into a cold sweat. After five minutes, he "sort of came to himself again."

An electroencephalogram showed a psychomotor pattern. This patient was given anticonvulsants and psychotherapy with excellent results.

CASE THREE

A 41-year old housewife, complained of periodic numbness involving the lips, tongue and fingers. She had occasional spells in which she had temporary impairment of vision. During these spells she could see only half an object. At other times she had visual attacks during which objects appeared blurred. She also complained of insomnia. She noticed frequently that when she had been visiting socially and had a pleasant evening, she was morose and depressed on her return home.

Encephalography revealed a psychomotor pattern. Treatment with anticonvulsants relieved all the symptoms.

CASE FOUR

A 26-year old housewife had had periods of marked jealousy and irritability. She refused to let her husband play golf. There were episodes during which she would create a scene, threaten to kill herself, run for a bottle of poison and make an attempt to drink it. On one occasion she tried to slash her wrists with a razor blade. Once while pregnant she attempted to "punish" her husband by beating her abdomen with her fist in an effort to destroy the fetus. On another occasion, during a temper tantrum, she threw away her wedding ring. Once she physically attacked her husband.

An electroencephalogram showed the pattern of psychomotor epilepsy. Anticonvulsants produced marked improvement of the symptomatic domestic disturbances.

CASE FIVE

A school girl reported that she had been having headaches for five years. She had been sent home from school on a number of occasions because of them. With the headaches she had visual difficulties. Her headaches typically lasted four or five hours, after which she felt exhausted and fell asleep. Upon awakening she had persistent dull pain, and was tired for the entire day. At times vomiting was associated with the headaches. The headaches were sharp, piercing, pulsating and came on suddenly. They occurred about every three weeks.

The electroencephalogram showed a pattern of psychomotor epilepsy. She was treated with anticonvulsants with the relief of symptoms.

CASE SIX

A 47-year old woman reports that she had lost about 16 pounds during the previous month. She suffered from anorexia and severe headaches followed by periods of depression which lasted from two to three days. She complained of insomnia, had no interest sexually in her husband and had been drinking excessively for a number of years.

An electroencephalogram showed a characteristic psychomotor pattern. The patient was given anticonvulsants, and psychotherapy. A much more successful social adjustment and the alleviation of symptoms ensued, together with marked gain in weight.

THE discussion and examples given indicate that many symptoms considered to be hysterical or psychotic phenomena are actually neither. In certain cases, these apparently "psychogenic" symptoms are actually due to organic disease with lesions in the temporal lobes.

Evidence supporting this opinion is the ab-

normal electrical activity revealed by electroencephalography. Even with the electroencephalogram many cases are missed. The technical reason for this is that with electroencephalography performed during the patient's waking state only about one-third of positive seizure patterns are noted. The number of positive records resulting from electroencephalograms taken during induced sleep is 300

per cent greater than from those taken during the normal or resting states.

Even when a positive diagnosis of psychomotor epilepsy is made it does not necessarily follow that anticonvulsants will relieve all the symptoms. The reason for this is that many times there are organic irreversible changes which medication cannot change. In such instances, surgical intervention may be helpful.

254 Union Street

Gamma Globulin*

1. During 1953, up to November 1, a total of 114 cases of poliomyelitis occurred in five contiguous Wisconsin counties. Of the 114 cases, 45 were resident in Polk County and 69 in four adjacent counties.

2. Gamma globulin was administered to 93 per cent of the children under 15 years of age in Polk County on September 15 and 16.

3. Epidemiological data from Polk County are compared with the aggregate of those from the other four counties. Reported cases are considered before and after the date of termination of the mass immunization program.

4. In Polk County, a total of 28 cases was reported in children under 15 years of age. Of these, five, or 17.9 per cent, occurred after the program in children who had received gamma globulin. In the other four counties, eight cases, or 19.5 per cent of a total of 41, were reported in the same age group, with onset after September 19. None of the latter had received gamma globulin. The difference is not significant.

5. There was a significant shift of incidence of nonparalytic cases from the lower to the higher age group in Polk County not due to gamma globulin. There is a normal change in age incidence to older age groups as poliomyelitis epidemics progress, but the high ratio of nonparalytic to paralytic cases in this group is unusual.

6. It is felt that psychological factors introduced by the program, combined with those

already present during the epidemic, were responsible for results of a significant degree.

7. There is no evidence that gamma globulin had any effect in altering the course of the poliomyelitis outbreak or preventing cases of the disease. The small number of cases which occurred after the immunization program did not permit an evaluation of possible modifying effects from the gamma globulin.

8. It must be emphasized that the immunization program in Polk County, as in most counties where it was conducted throughout the United States, was instituted not at or just before the epidemic peak, but after the peak of maximum incidence. The entire evaluation of the value of mass prophylaxis in poliomyelitis by gamma globulin must be considered from this viewpoint. Perhaps, with limited supplies and the necessary administrative and organizational measures required for such programs, mass immunization programs of this type are not feasible for maximum prophylactic effectiveness. Another most important factor is the delay in reporting of cases; the physician reports to the local health officer, and he reports to the district health officer. This method is one required by statute, yet it creates a lag in establishing the time when peak incidence is approached and adds to the other factors which impair timely organization for mass immunization.

*Graber, R. E.: Wisconsin M. J. 53:368 (July 1954).

ANTHONY D. CRECCA, M.D.

NICHOLAS A. ANTONIUS, M.D.

JOSEPH V. CRECCA, M.D.

JOHN J. MCGUIRE, M.D.

RALPH MILLER, M.D.

Newark

Surgery for Coronary Artery Disease*

Deaths from coronary disease continue to rise. Medical treatment has obviously failed to stem the rising tide of coronary deaths. The authors of this paper believe that surgical revascularization of the heart is the answer. They review the various surgical techniques, and recommend a combined Beck I and Vineberg procedure.

THE mortality from coronary artery disease is twice as great as that from cancer.¹ One of every four persons dies of coronary artery disease. Death from heart disease (excluding coronary disease) has decreased since 1930. But mortality from coronary artery disease has increased and continues to do so. It is necessary, therefore, to turn our efforts toward a more adequate, more positive and more direct treatment of coronary artery disease. This is a disease which causes its greatest mortality among men at precisely the most productive period of their lives. While the pathology of coronary artery disease is understood, its cause is, as yet, uncontrollable. The staggeringly high morbidity and mortality rates indicate that medical treatment is inadequate.

MEDICAL TREATMENT

MEDICAL treatment of coronary artery disease extends back to 1768, when Heberden² first established it as a clinical entity. At that time he wrote; "With the respect to the treatment of this complaint, I have little or nothing to advance, nor indeed is it to be ex-

pected we should have made much progress in the cure of a disease which has hitherto hardly made a place or a name in medical books. Quiet and warmth and spiritus liquors help restore patients who are exhausted, and to dispel the effects of a fit when it does not soon go off. Opium taken at bed time will prevent the attacks by night."

One hundred and eighty-five years have passed since Heberden first recommended quiet, warmth, spiritus liquors and opiates as the treatment for this disease. In the intervening two centuries, great advances have been made in the diagnosis and treatment of coronary artery disease and in the knowledge of its pathology. Numerous drugs have been made available for the control of symptoms. But not one iota of real progress has been made toward reversing the effect of coronary artery disease, namely, the inadequate oxygenation of the myocardium, caused by narrowing and/or occlusion of the coronary arteries.

*From the Departments of Cardiology and Thoracic Surgery, St. Michael's Hospital, Newark. This paper was read at the Annual Meeting of The Medical Society of New Jersey in Atlantic City, May 14, 1953.

Medical treatment was considerably improved by the discovery of amyl nitrite³ in 1867 and of nitroglycerin⁴ in 1879. It was not until 1933 that Lewis⁵ observed that the relief of anginal pain was due to an increase in the flow of blood through the coronary arteries. In the 1880's, the xanthine drugs⁶ became recognized as relievers of angina pectoris. In 1899, the effect of the xanthine drugs was proved to be vasodilatation of the coronary arteries. In 1939, Manning, McEachern and Hall⁷ demonstrated that, when a coronary artery is occluded, there is a reflex vasoconstriction of all the coronary arteries, decreasing the blood supply to all the heart muscle and in consequence, decreasing blood flow through anastomotic channels to the infarcted areas. This reflex vasoconstriction could be obviated by vagal section or by atropine. There are some who even credit the pronounced and prolonged vasodilator effect of Dicumarol[®] for its usefulness in the treatment of coronary artery disease. All these drugs owe their effectiveness chiefly to their ability to dilate the coronary arteries and increase the blood flow to the myocardium. In spite of these medical aids, the mortality and morbidity from coronary artery disease remain unchecked.

The pathology of coronary artery disease runs the gamut from vasomotor influence alone to irreversible anatomic changes in the vessel walls. Therefore, simple vasodilatation cannot be a lasting solution to this complex illness. Surely then, we must examine the possibilities of surgical methods for improving the blood supply to the heart and to combat the irreversible changes in the coronary arteries caused by this disease.

BLOOD SUPPLY OF HEART

The blood supply of the myocardium⁸ is from the two coronary arteries.⁹ The right coronary arises from the right anterior sinus of Valsalva. The left coronary comes from the left anterior sinus of Valsalva. The cardiac veins return the blood to the right auricle. They consist of the coronary sinus, which drains about 60 per cent of the heart's blood and almost all of the blood from the left ventricle, and the anterior cardiac veins, which enter the right auricle directly and arise on the anterior wall of the right ventricle. The deeper or myocardial vascular systems are the thebesian veins,

arteriololuminal vessels, arteriosinusoidal vessels and capillaries.

The *Thebesian veins* lie between the trabeculae carneae of the ventricles and auricles. They are small endocardial foramina which measure up to a millimeter in width. Some are in direct communication with coronary veins. Some end as blind pouches. Others anastomose with one another by intercommunicating subendocardial capillary networks. The endocardial foramina are probably remnants of the original sinusoidal system of the embryo heart.

Arteriololuminal vessels, described by Wearn,²⁶ are small communicating vessels between small coronary arteries, arterioles and the heart chambers.

Arteriosinusoidal vessels are small arterial and arteriolar branches which terminate in myocardial sinusoids.

Arteriovenous anastomoses (myocardial glomera) have been demonstrated by Prinzmetal.¹⁰

Capillaries parallel and encircle the muscle fibers and anastomose between them, but never pierce the muscle sheaths. At birth, there are six muscle fibers to each capillary. With growth, the number of capillaries increases to the point where, in the adult heart, there is a ratio of one capillary to one muscle fiber. This ratio of myocardial capillaries is almost twice the concentration of capillaries in the skeletal muscles. This ratio of one capillary to one muscle fiber exists throughout life, regardless of pathologic changes. This reflects the importance that nature has placed upon the blood supply to the heart. The entire vascular system of the myocardium is so well developed with intercommunications that it can adjust and distend (within limits) to accept an added blood supply without engorgement or thrombosis. Wearn²⁶ states that there are 94 million capillaries per cubic inch of myocardium. This makes the heart muscle a veritable marsh of blood channels and muscle fibers.

It is believed that a direct tidal exchange of blood can be developed between the cavities of the ventricles and the sinusoids of the myocardium itself, through dilated embryonic channels known to exist in some forms of animal life.

Coronary arteries were regarded as end arteries until Spalteholz and Gross⁹ demonstrated that anastomoses exist between the right and left coronary arteries and between branches of each coronary artery and between branches of the coronary arteries and the arteries surrounding the heart, the internal mammaries, the anterior mediastinal, pericardial, bronchial, intercostal, and oesophageal branches of the aorta. Prinzmetal¹⁰ injected glass spheres 10 to 440 micra in diameter into one of the coronary arteries and consistently recovered some spheres in the other coronary artery, in the coronary sinus, or in the ventricular cavities. In the wake of coronary narrowing or occlusion, a compensatory collateral circulation develops in proportion to the degree and duration of the arterial stricture and in relation to the area of myocardium supplied by the involved vessel. Blumgart, Schlesinger and Zoll¹¹ showed that these collateral anastomotic vessels are not a natural concomitant of aging but a compensatory response to coronary

narrowing or occlusion. Feil and Beck²² stated that the greatest stimulus to establishing collateral coronary anastomosis is the occlusion of a coronary artery.

The larger coronary arteries are composed of adventitia, media and intima which constantly undergo morphologic changes. In people past fifty, coronary intimal thickening is universal and atherosclerosis is common. It is difficult to distinguish between the aging process of the artery and the early stages of the diseased process (atherosclerosis). The elastic hyperplastic layer becomes progressively thicker during the third to the fifth decade until the intima is several times as thick as the media. At the same time, a considerable amount of connective tissue is laid down. It is in this layer after the fifth decade that the abnormal calcium and fatty deposits occur. Since the intima thickens with age and since atherosclerosis depends in part on intimal thickening, the age distribution of coronary artery disease is understandable. The predominance of the disease in males may be due to the fact that at birth and thereafter the intimal thickening of the coronary arteries in males exceeds that in females. The predilection of the various major coronary arteries to develop atherosclerosis probably depends on the variations of their structure, development and growth.

The myocardial arteries are the vessels within the heart parenchyma and have three layers. Their most characteristic change with age is the gradual replacement of media by proliferation of elastic tissue. After age 30, connective tissue starts to replace the smooth muscle cells but not until the sixth decade is the media transferred into a fibroelastic layer. After the seventh and eighth decades, myocardial arteries are frequently represented by a fibroelastic tube, with no remaining smooth muscle. Atherosclerosis is infrequently seen in the myocardial arteries.

PATHOGENESIS

Coronary artery disease in itself does not necessarily produce clinical manifestations. It is only when the damage becomes severe enough to cause a critical deficit of blood supply in proportion to myocardial demands, that symptoms occur. Angina pectoris results from a short period of relatively mild ischemia. Myocardial infarction results from severe and prolonged ischemia in a more localized portion of the myocardium, often from occlusion of one of the larger coronary arteries.

Blumgart¹² stated that coronary arteries are functionally end arteries in normal hearts. Injection of watery solutions into the coronary arteries revealed fine anatomic anastomotic communications between coronary arteries, measuring less than 40 micra. Even in patients of 70 years or more, with normal coronary arteries, this was found to be true. Blumgart¹² also observed that in 40 per cent of the patients past 40 years of age who died of noncardiac causes and who had no symptoms of cardiac disease, complete occlusion or considerable narrowing of one or more coronary ar-

teries was found. In these cases, larger than normal collateral channels originating in neighboring unoccluded arteries bypassed the obstruction and supplied the myocardium distal to it. This demonstrates the "demand effect" of the coronary insufficiency in stimulating the formation of new collateral anastomotic channels. It also points up the fact that by the time symptoms appear, the progress of the disease is well advanced. This is comparable to finding a tight mitral valve in patients whose symptoms of mitral stenosis are of only six to twelve months' duration.

Zoll, Wessler and Blumgart¹³ reviewed 1011 unselected autopsies, among which there were 177 cases with a history of angina pectoris before death. Six hundred and seventy-one cases with coronary pain were used as controls. Of these 177 cases, coronary artery disease was demonstrated in 90 per cent of the patients. Almost two-thirds had old coronary obstruction (an average of three occlusions per heart). The greater the degree of coronary obstruction, the greater was the incidence of angina. Grossly dissectable intercoronary anastomoses were found in 17 per cent of the hearts with old occlusions but never in normal hearts.

PROGNOSIS

WE OUGHT to know the natural history of coronary artery disease from its earliest onset until death of the patient.⁸ We should concern ourselves with the prognosis of the patients with coronary artery disease, rather than with the prognosis of angina pectoris, coronary thrombosis or coronary insufficiency. Most important is the question, "What are the chances of survival of the patients who have symptoms of coronary artery disease?"

White, Bland and Miskall¹⁴ reviewed 500 cases of angina pectoris and reported on them after 445 had died. The survival period of the 445 was 7.9 years. The 55 remaining patients had survived an average of 18.4 years at the time of the report. Eppinger and Levine¹⁵ cited 141 fatal cases with an average life duration of 4.5 years after onset of symptoms. Mackenzie¹⁶ reported on 380 patients after 214 had died. Average survival time of the 214 was 5.4 years.

The following authors have written on the survival in coronary thrombosis: Connor and Holt¹⁷ reported 287 cases with an immediate mortality of 16 per cent. Levine and Rosenbaum¹⁸ reported 372 cases. One-third of these were dead within 3½ years. Katz, Mills and

Cisneros¹⁹ followed 488 patients for as long as six years; one-fourth died in the first two months; half were dead by the end of the first year; and 75 per cent were dead by the end of the third year. Sigler²⁰ reviewed 1700 cases of angina pectoris and coronary occlusion. Forty per cent were dead at the time of the report. Their survival period was 5 years from the time of first symptoms. The living totalled 60 per cent of all the patients. Average follow-up was 5½ years from first symptoms. Black *et al.*²¹ reported on over 6000 cases of angina pectoris in 18 years with a follow-up of 5 to 23 years. Average duration of symptoms, before the diagnosis, was 2½ years. The ratio of male to female was 4 to 1. Mortality for this group was 15 per cent in the first year and 9 per cent yearly thereafter. The five year survival rate was 58 per cent.

On the basis of these reports on prognosis, the need for treatment to stem the ever-advancing progress of coronary artery disease is evident.

There is no method of preventing coronary artery disease. There are no medical means for halting its progress. For the time being at least, we must look to surgical technics for revascularizing the heart so that a new supply of arterial blood can be brought to the heart muscle.

METHODS OF REVASCULARIZATION

METHODS by which a new blood flow may be brought to the heart muscle are:

1. A new blood flow may be delivered to the heart muscle by way of collateral anastomosis between the coronary arteries and the surrounding vessels (internal mammaries, pericardials, intercostals, anterior mediastinals, bronchials and oesophageal branches of the aorta), or by collateral anastomosis between the coronary arteries with a direct implantation into the myocardium of a systemic vessel (Vineberg operation).²⁵

2. A new blood flow may be delivered to the heart muscle through existing channels. This has been accomplished by Beck and his

co-workers²⁴ who devised the aortic-coronary sinus shunt operation. This procedure delivers arterial blood into the venous system of the heart in an adequate amount for relief of symptoms and protection of the myocardium in the event of a subsequent coronary artery occlusion. This has been demonstrated in experimental animals and in patients who were submitted to this operation.

3. An improved flow through the existing sclerosed coronary arteries would be possible if a method were devised for correcting this condition, either medically or surgically.

On the basis of these three possible methods of bringing a new flow of arterial blood to the myocardium we here review the practical applications of these concepts as they have evolved into the following operative procedures that we use for the surgical treatment of coronary artery disease:

1. Epicardial abrasion and poudrage (Beck I).
2. Aortic coronary sinus anastomosis (Beck II).
3. Internal mammary artery implantation into left ventricular musculature (Vineberg²⁵).
4. Combined Beck I and Vineberg (St. Michael's Group).

Operations 1, 3 and 4 make use of the first principle enumerated as a possible source of new blood to the myocardium, while operation 2 makes use of the second principle.

From the third principle enumerated as a source of improved blood supply to the myocardium no successful technic for its application has as yet been evolved. Some drug to "dissolve" or prevent arteriosclerosis may eventually be developed and thereby solve the problem of coronary artery disease.

SURGICAL REVASCULARIZATION

IN 1932, Beck first demonstrated the existence of pericardial adhesions with adequate anastomotic channels between the pericardium and myocardium. Because of this Beck sought to produce cardiac revascularization by abrasion and poudrage of the epicardium and pericardium. In 1940 Feil and Beck²² reported on 30 patients with advanced coronary artery disease upon whom they had operated. The

technic consisted of abrasion of the epicardium and visceral surface of the pericardium, and spreading over these surfaces various irritants to stimulate increased vascularity between the pericardium and myocardium and between the intercoronary communications. Several of these patients had had previous operations (sympathectomy and thyroidectomy) in an attempt to get relief from severe anginal attacks. These operations were performed between 1935 and 1938. In most, a poudrage material of animal bone meal was used. The operative mortality of this group was 33 per cent. Such an operative mortality today would be prohibitive. However, when one considers that the operative mortality for lobectomy in 1935 was similarly high because of little understood problems of anesthesia and cardio-respiratory physiology, the early Beck mortality is understandable.

A review of the 20 patients who survived the abrasion and poudrage operation was reported by Feil and Beck.²² One patient died of pituitary cachexia 29 months after operation. Another died after five months of cardiac failure. These results were considered poor. Of the other 18 patients, 13 were classified as having a "good" clinical result. One of these died of cerebral hemorrhage 26 months after surgery. Four were considered to have a "fair" result. One patient died 14 months after operation of coronary thrombosis. Therefore, of the 20 survivals, 65 per cent had "definite" improvement, 20 per cent had "moderate" improvement, and 15 per cent had "inconsequential" improvement. An addendum to the original article, written a year later, reported that there were no more deaths in this group of patients and that all patients showed additional improvement.

The patient who lived 26 months with good clinical improvement and died of cerebral hemorrhage, at autopsy showed evidence that good anastomotic channels had developed. Feil and Beck concluded that the high ratio of improvement was not only significant but encouraging, especially since all these patients had serious, disabling disease. Leighninger,²³ in Beck's laboratory, has demonstrated a blood flow increase of 16 to 20 cubic centimeters per

minute from the cut distal end of the circumflex coronary artery in animals allowed to form collateral anastomoses after the poudrage operation. The normal flow is 2.8 cubic centimeters per minute.

Even though the clinical improvements in their series were encouraging, Beck and his collaborators continued to seek a better method for revascularizing the heart. Roberts suggested that the coronary sinus might be arterialized by anastomosing it with a systemic vessel. This led Beck and his co-workers to an extensive program of animal experimentation and finally clinical trial. The Beck II operation for revascularizing the heart by an aortic-coronary sinus shunt was the result.²⁴ It is performed by using a vein or artery graft to anastomose the descending aorta to the coronary sinus and thus diverting arterial blood into the venous channels of the heart to flow retrograde into the capillary bed. The operation is performed in two stages. In the first stage a shunt is created by anastomosing the aorta to the coronary sinus. The second stage is performed three to six weeks later. At this time the coronary sinus is narrowed to a lumen of 3 millimeters at its ostium to increase the flow of blood retrograde through the channels dilated, prepared, and created by the effects of the first stage of the operation.

IN THE experimental laboratory, Beck and his associates used more than 5,000 animals to establish the evidence and demonstrate the benefit from this operation. They developed a "test of benefit" for heart revascularization procedures. They showed that by ligating the descending ramus of the left coronary artery at its origin in one stage, 70 per cent of normal dogs would die. All dogs who survived showed a definite infarct—usually a large one. The test was applied to 37 dogs in whom arterial blood was shunted into the coronary sinus from a systemic vessel and the sinus partly or completely ligated at its ostium into the right auricle. In this group, 33 lived and 4 died. Without arterialization of the coronary sinus, 26 would have died. In the "protected" dogs there were no infarcts in more than half of the

specimens. In the others, the infarcts were small. Thus, we have evidence that the operation protects the dog against both death and myocardial infarction. It seems reasonable to assume, then, that oxygenated blood must reach the capillaries where oxygen exchange must occur to produce this protection. In two dogs, all coronary arteries were occluded except the septal branch after this protective operation and the dogs remained active and in good health.

Additional evidence that blood flows in a retrograde direction, probably through the capillary bed, is given by the following experiment. The circumflex coronary artery is dissected free and the proximal end is ligated in a dog protected by the Beck II operation. The artery is severed and the flow of blood from the distal end is observed and measured. When the graft from the aorta to the coronary sinus is clamped, the blood from the severed circumflex is red and flows in small amounts. It is arterial and probably enters by way of inter-coronary channels. When the graft is open, so that red blood enters from the aorta, the retrograde flow from the severed circumflex is blue. It flows in large amounts and can build higher pressure. The retrograde flow is augmented because of aortic inflow from the graft. It is blue because it has traversed the capillary bed and given up its oxygen. These experiments seem to establish the soundness of this method of revascularizing the heart by passing arterial blood into the coronary sinus and the venous system of the heart. Since we know that coronary artery disease does not involve the veins or capillaries of the heart, these channels are always available for use in this operation. Another advantage in using the venous channels for arterialized blood is the fact that these channels far outnumber arterial channels. Whether or not the arterial pressures in the venous channels can be tolerated over a long period of time remains to be proved. There is some evidence that under the force of arterial pressure these venous channels may thrombose after several weeks or months. However, the coronary arterial channels, under the stimulus of the arterial flow, improve the blood supply to the

myocardium since these patients maintain marked clinical improvement for months and years after operation.

The Vineberg²⁵ operation consists of implanting the internal mammary artery with bleeding open terminal branches into the musculature of the left ventricle. Here it joins with collaterals formed with the deep or myocardial branches of the coronary arteries and thus brings a new source of arterial blood to these myocardial arteries which are seldom involved in the pathology of coronary artery disease.

Vineberg has used hundreds of animals to perfect this operation. In one experiment the internal mammary was transplanted into the myocardium. Months later the descending ramus of the circumflex artery was ligated. No deaths or infarctions occurred in these animals. In a control group of dogs in which ligation of the descending ramus of the circumflex was done, without protection of the Vineberg operation, 70 per cent of the dogs died. In another experiment, Vineberg was able to create coronary insufficiency by wrapping the coronary arteries with cellophane. A group of dogs thus prepared were then exercised on a treadmill. After six weeks, the dogs showed increasing disability due to coronary insufficiency and, after six months, were completely incapacitated. At this point the Vineberg operation was carried out and the dogs were gradually able to regain full exercising ability. The patency of transplanted vessels and the development of collaterals improved with the demand for these collaterals. In dogs suffering from coronary insufficiency the patency incidence of the transplanted internal mammary artery was 90 per cent. In dogs in which there was no coronary insufficiency, the patency incidence was from 50 to 60 per cent. This indicates that where there is need for collaterals to develop, the demand stimulates the formation of these collaterals. Vineberg²⁵ has demonstrated the maintenance of full cardiac action in animals receiving blood solely from the internal mammary artery implanted into the myocardium months before. In these experiments all coronary arteries were ligated. The heart action continued normally until this im-

planted internal mammary artery was clamped, and with this maneuver the heart stopped.

Since coronary artery disease is primarily a disease of the superficial coronary arteries and not the deeper myocardial branches, this operation has a rational justification for its use and for the explanation of its successful "test of benefits," as worked out by Vineberg. The collateral vessels established between the transplanted internal mammary artery and the myocardial arteries allow arterial blood to be shunted past the diseased superficial main coronary arteries and into the deep myocardial arteries to nourish the heart muscle. Needless to say, collateral vessels also form between the pericardium and myocardium following the Vineberg operation, so that patients in whom the internal mammary vessel does not remain patent will still derive some benefit from this operation.

AUTHORS' EXPERIENCE

OUR experience with the surgical treatment of coronary artery disease consists of more than three years of experimental dog surgery with these procedures and their application in 26 clinical cases. Our work in the experimental laboratory and the tremendous amount of experimental and clinical evidence developed by Beck and his associates, and by Vineberg, convinced us of the soundness of the surgical treatment of coronary artery disease. Together with Beck we have operated upon fifteen patients for coronary artery disease. Our group working alone subsequently added an additional eleven cases to this series. These operations include 15 poudrage (Beck I) operations, 8 Beck aortic-coronary sinus shunt operations (Beck II) and 3 combined Beck I and Vineberg operations.

On the basis of our experience we have come to place great reliance upon the Beck I operation, which has been revised to include abrasion of the epicardium and visceral surface of the pericardium, poudrage of these surfaces with finely ground asbestos powder and ligation of the coronary sinus to a lumen of 3 millimeters just proximal to its ostium. By

this procedure we get a summation of the benefits of the abrasion and poudrage effect, plus the protection derived from partial ligation of the coronary sinus at the ostium.

In three patients we combined the Beck I operation with an internal mammary artery implant with good effect. We have added the internal mammary artery implant to the Beck I operation because Vineberg has demonstrated collateral anastomoses between the implanted vessel and the myocardial arteries within twelve days, thus bringing early postoperative protection to these patients. Since this maneuver requires only little additional time we feel that, in better-risk patients, it can be used with safety. Perhaps this combined procedure will become the one of choice in the treatment of coronary disease.

The results obtained to date with our 26 operative cases are as follows: Eight Beck II procedures (aortic-coronary sinus anastomosis) were done. There were two operative deaths. The other six patients obtained good results.

Fifteen cases of the Beck I procedure (poudrage, abrasion, and partial ligation of the coronary sinus) were done. There were no deaths in this group. The results were good in 14 cases and fair in the other.

Three combined Beck I and Vineberg procedures have been done. The results in all three are encouraging but the operations have been done too recently for final evaluation.

With one exception, all our patients who have successfully undergone surgery, are improved. There have been no late mortalities. The operations were performed between February 1951 and July 1954.

SUMMARY

1. The history of the medical treatment of coronary artery disease is briefly reviewed, and the inadequacy of medical therapy is pointed out. The mortality statistics of this disease emphasize the need for a more direct therapeutic approach.
2. The pertinent features of the anatomy,

histology and pathology of coronary artery disease are reviewed. The rationale for surgical treatment is developed. Various procedures available to the surgeon for the creation of a new blood supply to the myocardium are discussed.

3. The results in our first 26 cases of surgical treatment of coronary artery disease are

reported. The following procedures were done: Aortic-coronary sinus anastomosis; modified Beck I operation (poudrage, abrasion, and partial coronary sinus ligation); and the combined modified Beck I and Vineberg procedure.

4. There were two deaths in this group. The other 24 cases all showed improvement.

ADDENDUM

Recently we have used omentum to anastomose the systemic arteries with the coronary arterial system. During the usual Beck I operation, an incision one to two inches long, is made in the parasternal area of the diaphragm, exposing the peritoneal cavity. Using a long sponge forceps, the omentum is grasped and delivered into the thoracic cavity. The omentum is then sutured to the edges of the large windows previously created in the pericardium.

The omentum is thus in position to develop anastomotic channels with the coronary arterial system. This procedure is easily performed and is less traumatic than the internal mammary artery implant operation. Studies, previously made on this procedure, indicate that a copious number of anastomoses develops between the omentum and the coronary arterial system.

306 High Street

A bibliography of 26 citations is included in the authors' reprints.

Mouth Protectors in Sports

Although they prevent widespread mouth injuries, and in some cases death, the use of mouth protectors in various sports is not sufficiently popular. College, high school, and grammar school football, baseball, and other "contact" sports are increasing in participants . . . and dental injuries. Schools spend an average of \$120 each year on protective clothing for a football player. The protection is for regions in which 48 per cent of the injuries occur. "Only a limited number of schools make any attempt to provide any sort of protection for the region where 52 per cent of the injuries occur."*

Using functional mouth protectors in "contact" sports provides several advantages. The

mouth and associated structures are protected. The force of most blows transmitted to the brain is minimized, usually avoiding the subsequent unconsciousness, concussion with permanent or cumulative brain injury, and even death.

Mouth protectors have been used since 1927, especially in boxing. Their widespread use has been hindered by ignorance of the problem, by the general public and by previous expense involved in the preparation of mouth protectors.

*Watts, G., Wollard, A., and Singer, C. E.: Functional mouth protectors for contact sports, *J. Am. Dent. A.* 49:7 (July) 1954.

Trustee Actions

At its August 24 (1954) session, the Board of Trustees:

—Considered a request from Seton Hall College of Medicine and Dentistry that the Society appoint a liaison committee for the College's "guidance and direction." The Board directed the Secretary to reply that the Society was gratified at the invitation, and that when specific information was received regarding the responsibilities and functions of such a liaison committee, consideration would be given to establishing it. In the interim, the advice and guidance of our Committee on Medical Education were placed at Seton Hall's disposal.

—Adopted a resolution urging the Governor to sign S-317.*

—Indicated its approval of an "appropriate tax" to finance the proposed medical school "under university auspices and supported by general tax funds."

—Received a report from the Medical-Dental Liaison Committee that efforts towards the establishment of a medical-dental school were properly a joint function of both societies. It was decided to establish an overall committee to "cooperate with all groups interested in

working towards the passage of the referendum."

—Received the nominations of Drs. Jesse McCall, Henry B. Decker, and C. Byron Blaisdell as members of the Medical-Dental Liaison Committee. Dr. McCall will be chairman. The President and Executive Officer will have *ex officio* seats on that committee.

—Approved the nomination of Dr. Joseph I. Echikson as a member of the corporation and board of trustees of Medical-Surgical Plan.

—Authorized the designation of Drs. Marcus Greifinger, William Costello, and Carl N. Ware as a committee to review the professional audit for the current fiscal year.

—Regretted inability to make a donation to the Medical Library Association towards scholarships for medical librarians.

—Authorized the Treasurer to cash and reinvest the proceeds of matured Government bonds held by the Society.

*This is the bill which calls for a referendum on November 2 on the citizens' desires to have and support a medical-dental school. Governor Meyner signed the bill on September 20.

Approved Internships in New Jersey

The September 25 (1954) issue of the *Journal of the American Medical Association* carries a wealth of information on residencies and internships in this country. The material here presented is abstracted from, paraphrased from or based on figures in that report.

There are about 10,000 approved internships in the country. As of June 1954, 8275 of these were filled and the rest were vacant: a vacancy ratio of 22 per cent. New Jersey fared better. Of its 357 approved internships, only 63 were unfilled, a vacancy ratio of 18 per cent. New Jersey with 3 per cent of the country's population, had 3½ per cent of its approved internships and 4.7 per cent of its approved hospitals. As used here "approved"

refers to accreditation by the Council on Medical Education and Hospitals of the American Medical Association. These figures reflect the picture in New Jersey and adjacent states, as against the national figures in the last line of the table.

One state, New Hampshire, has filled 100 per cent of its internships. However, New Hampshire has only one approved hospital (Mary Hitchcock in Hanover, N. H.). Apart from this, the best ratios are in Vermont (95 per cent), in Arizona (93 per cent) and in Florida (90 per cent). In New Jersey, 82 per cent of the internships are filled, which is appreciably better than the national average of 78 per cent. At the bottom of the list, in this

respect, are Indiana (55 per cent), Montana (47) and Arkansas (44 per cent).

In New Jersey are 4.7 per cent of the ap-

proved hospitals, but only 3.6 per cent of the approved internships. By contrast, New York has 12½ per cent of the approved hospital and 14½ per cent of the approved internships.

June 1954	Approved Hospitals	Approved Internships	Filled Internships	Per Cent Filled	Per Cent of U. S.	
					Hospitals	Internships
New Jersey	40	357	294	82	4.7	3.6
Pennsylvania	76	761	534	70	9.1	7.2
Delaware	3	28	22	79	0.35	0.27
New York	106	1547	1371	82	12.7	14.6
Connecticut	21	194	143	74	2.5	1.8
U. S. A.	836	10542	8275	78	100.0	100.0

New Jersey Hospitals approved for internships, together with the number of such approved internships are:

Atlantic City—12	Hoboken-St. Mary's—13
Bayonne—8	Jersey City—Christ Hosp.—10
Camden-Cooper—12	Jersey City Medical Center—30
Camden-West Jersey—9	Jersey City-St. Francis—8
East Orange General—4	Long Branch-Monmouth Mem.—8
Elizabeth-Alexian—6	Montclair-Mountain-side—10
Elizabeth General—10	
Elizabeth-St. Elizabeth's—9	
Englewood—6	
Hackensack—10	

Morristown-All Souls—3	Paterson-St. Mary's—4
Morristown Memorial—7	Paterson-St. Joseph—10
Neptune-Fitkin—8	Paterson-Barnert—6
Newark-Martland Mem.—10	Paterson General—8
Newark-St. Barnabas—8	Perth Amboy Gen.—9
Newark-St. Michael's—12	Plainfield-Muhlenberg—10
Newark-Beth Israel—12	Summit-Overlook—12
Newark-Presbyterian—4	Teaneck-Holy Name—7
New Brunswick-St. Peter's—2	Trenton-St. Francis—10
Orange Memorial—8	Trenton-Mercer—9
Paramus-Bergen Pines—20	Trenton-McKinley—5
Passaic General—5	Weehawken-North Hudson—6

Approved Residencies as of January 1, 1954*

As of January 1954, the Council on Medical Education and Hospitals (AMA) had approved of 23,628 residencies in all specialties. Of these, 18,617 were filled. The vacancy ratio was 21 per cent. Re-arranged in order of size of program, here are the figures.

Specialty	Nationwide (USA) Figures			New Jersey Residencies
	Total	Filled	% Filled	
Surgery	4806	4237	88	76
Intern. Med.	4547	3664	81	67
Psychiatry	2335	1632	70	27
Obst. & Gyn.	1918	1682	88	31
Pathology	1623	974	61	43
Radiology	1412	1027	73	16
Pediatrics	1361	1194	88	18
Anesthesia	949	746	79	8
Orthopedics	905	718	78	5
Urology	604	446	74	11
Ophthalmology	579	507	88	5
Gen. Practice	499	289	58	6
Pulmonary Dis.	382	250	66	22
Otolaryngology	378	251	67	0
Neuro-surgery	270	216	80	0
Derm. & Syph.	251	207	83	0
Neurology	250	160	64	0
Physical Med.	137	68	51	0
Thoracic Surg.	133	120	91	2
Plastic Surg.	69	62	90	2
Cardiovascular	68	54	80	0
Malignancies	35	21	60	0
Contagious Dis.	33	33	100	2
Gastro-enterology	32	28	88	0
Allergy	27	17	72	0
Proctology	25	13	52	0
U.S.A.	23628	18617	79	341

*Adapted and re-arranged from Journal of The American Medical Association 156:321 (1954).

Obituaries • • •

DR. L. ELMORE HESS

Dr. L. Elmore Hess, one of Atlantic County's best known practitioners, died at his home on August 31.

Dr. Hess was born in Brooklyn in 1890. A graduate of Temple University Medical School, class of 1923, he began his practice in Absecon in 1925. He was a veteran of World War I, having served in the Navy.

Dr. Hess was track physician at the Atlantic City Race Course since its opening nine years ago. He was the Board of Health doctor of Absecon, Port Republic and Galloway Township. He was school physician for Absecon, Absecon Highlands and South Egg Harbor. He was active in civic affairs and was an avid sportsman, enjoying hunting and fishing.

DR. OTTO LOWY

One of New Jersey's medical pioneers died on October 12 with the passing on that day of Dr. Otto Lowy. Born in Czechoslovakia in 1879, he came to the United States in 1892. He was graduated from the medical school of the University of Virginia in 1900. Thereafter he went to Vienna and Berlin, and did graduate work with Paul Ehrlich. He returned to the United States in 1902, and opened an office in Newark where he practiced for forty years.

Dr. Lowy was a pioneer in pathology. He had one of the earliest physician-operated laboratories of clinical pathology in the east. He was instrumental in introducing Ehrlich's original "salvarsan" into this country. This was before "neo" was developed and the administration of the unbuffered "salvarsan" required considerable craftsmanship. He received one of the first franchises in this country to refine, package and distribute the intravenous arsenicals for anti-luetic use. Dr. Lowy also did pioneer work in industrial toxicology, particularly in the biochemical aspects of lead poisoning. He headed up a research project on the effect of the coal-tar products on the blood cells. Dr. Lowy was also, in

a sense, a pioneer in the development of the small medical office building. In the late 1920s, when practically every New Jersey doctor had home and office together, Dr. Lowy converted his 4-story Clinton Avenue home into a physicians' office building. This was one of the earliest such ventures in the east, and it still functions as "The Lowy Building."

DR. WALTER R. TYMESON

One of Essex County's senior otolaryngologists died on September 27. Dr. Walter R. Tymeson, an emeritus otolaryngologist at the Orange Memorial Hospital, was born in Damascus, Pa. in 1885. He came to Orange in 1912, after being graduated from the Baltimore Medical School, as an associate of the late Linn Emerson. After serving in World War I he began to specialize in ophthalmology and otolaryngology. It is believed that Dr. Tymeson's 40 year period of service established a record there. He was a member of the Society of Surgeons of New Jersey.

DR. ALEXANDER E. WRENSCH

More than half a century of medical practice came to a close on September 22 with the death on that date of Dr. Alexander E. Wrensch of Caldwell.

Dr. Wrensch, formerly an active and later an emeritus member of the Essex County Medical Society, was born in Cedar Grove in 1876. He lived all his life in West Essex, first in Cedar Grove, later in Montclair and later in Caldwell. Originally a pharmacist he subsequently took up the study of medicine and was graduated from the University of Maryland with an M.D. degree in 1901. For 47 years thereafter he practiced in Montclair. During all that time he was active on the staff of the Mountainside Hospital and was one of its oldest doctors at the time of his death. He was a member of the Academy of Medicine of New Jersey and of numerous civic organizations in West Essex.

Announcements • • •

E.E.N.T. Seminar in Miami Beach

Physicians looking for an excuse to go to Florida this winter are reminded of the University of Florida's Midwinter Seminar in ophthalmology and otolaryngology at the Sans Souci Hotel in Miami Beach the week of January 17, 1955. Lectures on ophthalmology will be presented on January 17, 18, and 19 and those on otolaryngology on January 20, 21, and 22. A midweek feature will be the Convention of the Florida Society of Ophthalmology and Otolaryngology on January 19. The registrants and their wives may also attend the informal banquet at 8 p.m. on Wednesday. The Seminar schedule permits ample time for recreation.

Lecturers on ophthalmology this year are: Dr. William F. Hughes, Jr., Chicago; Dr. Phillips Thygeson, San Jose; Dr. James Allen, New Orleans; Dr. Walter H. Fink, Minneapolis; and Dr. Milton L. Berliner, New York. Those lecturing on otolaryngology are: Dr. Paul Holinger, Chicago; Dr. Lawrence R. Boies, Minneapolis; Dr. Edmund P. Fowler, Jr., New York; Dr. Arthur W. Proetz, St. Louis and Dr. David D. DeWeese, Portland, Oregon.

Nomenclature Institute

A new short course offering expert instruction and helpful suggestions on utilizing the "Standard Nomenclature of Diseases and Operations" in the hospital, office or clinic will be offered February 7-8-9, 1955 at AMA Headquarters, Chicago.

The three-day Nomenclature Institute program will be divided into three parts: (1) Lectures covering basic principles, construction, installation plus discussion on the tumor and operation sections and handling of specific problems; (2) anatomy as it pertains to the topographic section, and (3) practice in coding to be offered at two evening sessions.

Registration is limited to 150.

Instructors will be Adaline C. Hayden, R.R.L., associate editor of Standard Nomenclature, AMA, and Edward T. Thompson, M.D., F.A.C.H.A., Chief of Programs Operation, Hospital Facilities, USPHS, Washington, D. C.

The Miami Meeting

Sunny skies, swaying palms and broad sandy beaches are but a few of the attractions Miami offers physicians and their wives planning to attend AMA's eighth annual Clinical Meeting November 29 to December 2. An excellent scientific program plus a large array of technical exhibits have been lined up for AMA visitors.

This year's program stresses the practical everyday problems of the general practitioner. The lecture program will include subjects of broad interest in the fields of medicine, surgery, pediatrics, psychiatry, and obstetrics. Motion pictures will be shown continuously. Bringing the operating room directly into the lecture hall, color television programs will originate from the Jackson Memorial Hospital. The Scientific Exhibit will feature 80 exhibits, and demonstrators will be on duty throughout the week to answer physicians' questions.

Jamaica Calling!

No, we don't mean Jamaica, Long Island. If you go to the AMA meeting in Miami, you are invited to a post-convention meeting of the British Medical Association, at Kingston, capital city of Jamaica. That's on Saturday, December 4, at 10:00 a.m. The Jamaica Medical Association was founded in 1877.

Jamaica is reached from Miami by airliner in a pleasant 2½ hour trip over the Gulf Stream, across Cuba and a corner of the Caribbean. Following the close of the AMA meeting on Thursday, December 2, doctors and their wives could fly to Jamaica on Friday, attend the British Medical meeting Saturday forenoon, December 4, then enjoy the attractions of the popular tourist island as long as desired, returning to Miami in about three hours.

Further details will be available at Information Desks at the Miami meeting, from American Express Company and local travel agents, or from the Jamaica Tourist Board, 1631 du Pont Building, Miami, Fla.

Jargon Jars the Reader

Each month in this space, the Publication Committee or the Editor will present a problem in medical writing. Here, too, we will answer questions about the JOURNAL in particular or medical writing in general.

Jargon and gargle come from the same word source. In the doctor's lexicon, jargon is the inept, inaccurate quasi-technical word or phrase which the doctor uses carelessly because it comes so readily to his lips. "A case of malaria was admitted to the hospital yesterday" is, so to speak, a case in point. Of course it was a patient who was admitted, not a case. In this usage, "case" is jargon. The rule is really simple, and no literate person need be confused. (And after all, no one ever heard of an illiterate doctor). "Case" is proper if it can be replaced with the word "example" or "instance." So; "Freidrich's Ataxia: Report of a Case." This is all right, because "Report of an Example" makes sense. Similarly it is acceptable to write "... analysis of 220 cases of ainhum reveals that ..." It is acceptable because you *could* say "200 instances of ainhum."

But you do *not* operate on a case of appendicitis. You operate on a *patient*. In this instance, you could not replace "case" with "instance." Nor does a case ever die or get well.

To say *lues* or *luetis* when you mean "syphilis" or "syphilitic" is to use jargon. An *acute ear* is jargon for an "acutely inflamed ear." *Positive serology* is all right in staff room conversation. It does not belong in a scientific manuscript. Laymen often say that "the patient had a temperature." One does not expect a physician to perpetrate such an absurdity. Many doctors who ought to know better write that the symptoms were "suspicious of ..." when they mean "suggestive of ..." To say that the patient recovered in "a high percentage of cases" borders on the illiterate. The word "percentage" is used only with figures. "The mortality percentage fell from 60 to 15." This is awkward, but technically correct usage. It is not correct to say that the percentage of improvement was better with X than with Y.

To say "cholelithiasis" when you mean "gall stones" is to be pretentious. It is pretentious

to write "pyrexia" when you mean fever. In modern medicine we avoid eponymic designations like Koch's Disease or Neisserian infection. It is silly to write "in the majority of cases" when "in most cases" will do. To write *pathology* when you mean "disease" and *symptomatology* when you mean "symptoms" is to indulge in jargon. (*X-rays showed no pathology but the patient had the symptomatology of bronchiectasis* is an example of this double-talk.)

You might require the chief of the service to be a board diplomate. You would scarcely expect him to be a "board member." Any doctor who speaks of a *board member* when he means "board diplomate" should have a refresher course.

Latin is an honorable tongue, and a familiarity with Latin is the sign of an educated man. But it is sheer pretentiousness to use such Latin phrases as *morbilli*, *in situ*, *facies*, or *pes planus*. In the editors' gallery a hot foot is the fate of the exhibitionist who puts on airs by saying *pes planus* when plain "flat foot" will do.

Times change and the jargon of yesterday may be acceptable today. Not long ago, it was a solecism to use cardiac, epileptic, postmortem, convalescent, alcoholic or juvenile as nouns. These were adjectives, and the author was expected to write "patient with cardiac disease" or postmortem examination" or "convalescent patient." Most editors will accept them today as nouns.

As recently as 1948, Fishbein* was refusing to accept "cystoscope" as a verb. He wrote: "Astronomers never telescope the sky; but urologists do not hesitate to cystoscope their patients." His theory was that you could no more cystoscope a patient than you could stethoscope a chest, microscope a slide, explore an abdomen, Wassermann a "suspect," or obstetricate a birth. But time marches on, and it is part of the genius of the English language that a word may be used flexibly as noun, verb or adjective. Only an obsessive editor would today reject "cystoscope" as a verb or "alcoholic" as a noun. Perhaps tomorrow you will be able to microscope a specimen or stethoscope a lung. But not today.

Forsan et haec olim meminisse juvabit.

*Fishbein, Morris: Medical Writing. Philadelphia, 1948. Blakiston, Ed. 2. Page 48.

The First Person Singular in Medical Writing

When a medical author refers to himself as "we," I conjure up the picture of a stuffed shirt. Here is John Jones, M.D., writing: "Since 1946, we have been using histamine to test . . ." Does Dr. Jones think he is Emperor Jones—using that royal "we"?

It seems to me (not, please note, it seems to us) it seems to me that the plural should be reserved for clinics, groups, multiple authors and editors.

I never could understand the pretended aversion to the naked pronoun "I." It's alleged to be a sort of modesty. But any psychiatrist will tell you that it is a kind of grandeur. For instance, here is an author—just one individual practitioner—who says "We have had good results with amphetamine . . ." Does he want me to believe that he is head of a clinic or something? If it hurts him to say "I have had good results," then let him use some circumlocution; such as "Amphetamine was found successful in . . ."

It's not that I like to see a rash of "I's" in a medical paper. For instance, there is not much sense in writing "I believe" or "in my opinion" because it is obvious that the whole article is simply the author's opinion. An author says "I believe that larger doses should be given in . . ." Suppose he omits the first three words. It reads "Larger doses should be given in . . ." That means the same thing with or without the "I believe . . ." In either event it is not a decree from Mt. Olympus but simply the author's opinion. Or suppose the author writes: "The drain, in my opinion, should not be permitted to . . ." He could omit the "in my opinion" and it would *still* be his opinion. So why waste three words and

clutter up the manuscript with too many first persons singular?

On the other hand, I like to see "in my experience." That's quite different, if the author sets it up by way of contrast with standard opinion. Thus: "Although Bulgarian belladonna has been widely praised as the most potent form of the drug, in my experience, the American variety has been equally effective." There the author was quite right to say 'in my experience.' Otherwise the reader might get the impression that this was general medical opinion.

If a journal publishes a spoken paper without editing it, you are likely to find such expressions as "I have no doubt that . . ." or "I do not hesitate to say that . . ." These sound smooth enough in speech but are sheer padding in writing. Suppose the author writes:

(a) I do not hesitate to recommend tincture of musk in all cases of logus on the bogus.

(b) Tincture of musk is indicated in all cases of logus on the bogus.

These two mean the same thing. They mean the same because even without the "I do not hesitate," the second sentence is still nothing but the author's opinion. So why not use the shorter form? The same applies to such phrases as "There is no doubt in my mind about the value of tincture of musk . . ." The flat statement means no more than the "doubt in my mind." And besides, where else would you have doubt, if not in your mind?

HENRY A. DAVIDSON, M.D. *Editor,*
THE JOURNAL.

Bulletin on Rheumatic Diseases

Dr. Russell Cecil announces that the *Bulletin on Rheumatic Disease* is available without charge to licensed physicians. Write to Dr. Cecil at the Arthritis and Rheumatism Foundation, 23 West 45 Street, New York 36, N.Y.

This *Bulletin* appears nine times a year. Also available, at a cost of \$1 are a few sets of all previous (1950-1953) issues bound into a single volume.

Letters to the Journal • • •

Dear Doctor Davidson:

Your editorial on "Health Organization and Collection Boxes" in the September 1954 issue of THE JOURNAL sounded a note which will find distinct favor among many supporters of the voluntary health organizations, who are objective enough to see the need for a coordination of their very laudable but unrelated efforts.

The proposed step for the "doctors to take the initiative in creating a central control committee to which all such groups would be accountable" has much to commend itself. But the organization of such a central committee would have to find a way of reconciling the grounded interests of physicians in specific health organizations, usually along the lines of their specialized practices, and the overall view which should prevail in order to find a balanced program which would unite them all.

Such a central committee would have to be prepared to do yeoman work to persuade the enthusiastic supporters of a given voluntary health organization to be willing to coordinate their efforts for the common good of all the people whose health maintenance is their concern.

A central control committee could render a distinct service by having each voluntary health organization present a comprehensive report: (a) on their actual accomplishment in relation to the specific health program which it sponsors and (b) the monetary cost of carrying out the various phases of the program.

On the basis of these facts it should be possible to place the accomplishments of a given voluntary health organization in their proper relationship to the efforts of all other voluntary health organizations and offer the sponsors of the voluntary health organizations a sound and firm basis for their support.

EMIL FRANKEL, Ph.D.

Dear Dr. Davidson:

When I entered medical school in 1929, pharmacists compounded about 80 per cent of doctor's prescriptions. Today, according to *American Druggist*, only 7 per cent of Rx's require actual compounding.

This momentous shift to ready-made medicines has enticed many people into the drug manufacturing business. It is now one of the most competitive industries in the nation. To stave off bankruptcy, a new firm has to market new ready-made drugs at a merry clip. In fact, *Medical Economics* states that more than 1700 new prescription drugs were introduced within the last five years. Many are not really necessary, but are pushed for competitive reasons. What happened as a result of this? The pharmacist complains he must stock multiple brands of the same medication, creating higher in-

ventories and higher cost to the consumer. The physician is inundated with four color advertisements stating that John Doe's brand of penicillin is superior to all others.

How does a doctor in general practice keep up with new drugs today? It is difficult even for a specialist. As a practicing allergist, I find it almost impossible, even in my narrow corner of internal medicine. There were some thirty antihistamines on the market at my last count. Only three or four are really necessary. Let us assume a physician wants to prescribe hydrocortisone for a bad asthmatic. Should he write tablets Hydrocortone® (Merck), Cortef® (Upjohn) or Cortril® (Pfizer)? Each is proclaimed to be superior to the other two. If "A.R.B." were to be adopted the pharmacist could stock just one brand of hydrocortisone.

What do the manufacturers say about this? Following are some typical comments: "The worst possible thing that can happen to pharmacy and public health;" "'Any Reliable Brand' becomes 'Any brand.'" "The doctor should spell out what he wants." "Merely a pseudonym for substitution; it would sound the death knell of pharmacy's pretensions to a science and profession."

After all, to have a successful business you must feel that your product is better than the next fellow's. So the manufacturer vigorously condemns "ARB" as violative of the spirit of free enterprise. When you point out that USP and NF and FDA set standards and that *all* brands conform to them, the pharmaceutical manufacturer replies with a hurt voice, "but even so, my brand is better than the others."

Truth is, that, to some extent, ARB is already in operation. Hospital pharmacies, for instance, stock only a few brands. And of course many physicians just prescribe penicillin, confident that the pharmacist is not going to cheat the patient by dispensing an ineffective brand.

Do doctors of this state think that the ARB idea should be extended?

FRANK L. ROSEN, M.D.

Dr. Rosen is editor of the Bulletin of the Essex County Medical Society, as well as an allergist. The letter printed above was based on a talk Dr. Rosen gave at a symposium at Rutgers University College of Pharmacy, October 13, 1954.

The plan, in brief, is this. Let the physician write down a generic name for the product: cortisone, penicillin, amphetamine, or whatever it is. He then adds "-ARB" which means "Any Reliable Brand." If instead of writing amphetamine, he had written Benzedrine®, the pharmacist, of course, would have been

obliged to dispense the Smith, Kline and French brand, since that is their registered trade-name. The difficulty with the present widespread use of trade-names is that the pharmacist has to stock dozens of different brands, which in the long run, so increases his investment and inventory that he has to charge the patient more to counteract this. It also causes this kind of absurd situation: you write an Rx for, say Novocain®. Now the pharmacist may have six other brands of procaine, but he happens to be out of the Winthrop-Stearns brand which is the only kind he can prescribe if you write Novocain®. So the patient is told "no" and he has to wander from one store to another, even though the store he went to in the first place, could have met his needs if the doctor had written "Novocain® or ARB of Procaine."*

This is the argument in favor of ARB. On the other side of the fence is the fear that the pharmacist is not a reliable judge of reliability. Some physicians say that if every pharmacist could decide for himself which company was reliable and which was not, we would have chaos. Furthermore, some pharmacists might dispense the brand that they could buy at the lowest wholesale price, but would charge the patient the price normally set for the most expensive brand. In other words, the fear is that the ARB system would lead to savings which would accrue to the pharmacist not to the patient. Finally, there is the argument that the manufacturing pharmaceutical industry has invested so many millions in developing new drugs, that they are entitled to the protec-

tion afforded by a monopoly of the tradename. If the company cannot reap the benefits of a monopoly of a certain tradename, they might stop doing research. Why, they could ask, should we invest a million dollars to develop a nontoxic effective antibiotic, when a fly-by-night firm across the street can copy our formula and produce a cheaper brand? Today, at least, we have the protection of the tradename. If you want Combiotic®, you must get Pfizer's, for no one else may use that word. If you want Adrenalin®, it must be the Parke Davis product, for they own that name. So, Nembutal® means Abbott; and Premarin® is Ayerst. If you say Argyrol® you get the product that the Barnes Company did their pioneer research on. So, too, Empirin® means Burroughs Wellcome and Pyribenzamine® means Ciba and nobody else. Vaseline® is a trade-name. The Chesebrough Manufacturing Company is the only manufacturer who may use it. Vifort® means Endo; Prostigmin® means Hoffman-La Roche; Artane® means Lederle; Amytal® means Lilly, and so on down the alphabet to Wyeth and Kaomagma®. Will companies continue to sink millions in research to develop these products, if a competitor, or worse yet a Johnny-come-lately, can prescribe a cheaper variant, and get into the retail pharmacies through the door left open by ARB?

Got any answer, doctor?

—Editor

* In this connection, see Dr. Huberman's review of the *Manual of Antibiotics* on the bottom of page 496 in this issue.

Courses in Asphyxia

About 35,000 Americans die every year because of asphyxia. Asphyxia may develop through carbon monoxide poisoning, choking, anesthesia, foreign bodies, electric shock, drugs, drowning and other causes. Treatment must be swift, and the available resuscitation apparatus must be used intelligently. To this end, the Society for the Prevention of Asphyxial deaths gives frequent 1½ day courses

in the theory and practice of resuscitation. Such courses are periodically given in New York City. In addition, the course will be given in your own home town if you can recruit twelve or more persons to attend. For details write to the Society for the Prevention of Asphyxial Deaths, 2 East 63 Street, New York 21, N. Y.

County Society Reports • • •

Atlantic

A regular meeting of the *Medical Society of Atlantic County* was held at the Children's Seashore House, September 10, Dr. Matthew Molitch presiding.

The scientific program was presented by Edward O. Harper, M.D., Professor of Psychiatry, Western Reserve University. He talked about grief, a pathologic reaction when something is lost. The physician can be of help. Grief may cause some patients to develop melancholia and definite depression. Specific treatment would then be necessary. Dr. Harper went on to discuss the patient who is to die and the patient who is chronically ill.

The business meeting was opened by Dr. Molitch, who expressed thanks to Dr. Vandegrift for the excellent meeting room.

Minutes of the previous meeting, May 14, 1954, were approved as printed in the September *Bulletin*.

Dr. Erber reported that the Emergency Service functioned satisfactorily because of the splendid work of Drs. Joy, Demeo, Milano, Lippman, Linsk, and Abrams. The Service will be continued during the winter.

A motion was passed to limit the buying of space in publications.

Another motion was passed to the effect that a donation of \$10 to a charity designated by the family should be made in honor of a deceased member rather than the sending of a floral wreath.

A motion was made to have the Chronically Ill Committee express to the City Commission the desire of our Society to have the Communicable Disease Hospital sold to persons who could utilize the building so as to care for chronically ill patients. In this way the city would be helping to fill a need of the community. The motion was discussed and passed.

Nine applications were referred to the Censors Committee. The meeting was adjourned at 9:45 p.m.

LEONARD B. ERBER, M.D.
Reporter

Camden

President Harold K. Eynon inaugurated the regular monthly meeting of the *Camden County Medical Society* on October 5, 1954, at the Camden Medical Building.

Doctors Adolf Fuhrman, Llewellyn W. Hunsicker, Frank Orland and George A. Rogers were introduced to the Society after taking the membership oath.

A schedule of forthcoming programs was reviewed by Dr. Robert A. Cooper, Chairman of the Scientific and Literary Work Committee. Dr. David

F. Bentley introduced the guest speaker, Dr. David M. Davis, Emeritus Professor of Urology, at the Jefferson Medical College. His topic was "Prevention of Recurrence of Urinary Calculi." It was discussed by Doctors Bentley, Wright, Betancourt, Drake and Pulliam.

Treasurer Robert N. Bowen offered a concise report and advised the members that the ten dollar increment in dues this year includes five dollars for the State Society and five dollars for the County Society.

With the approach of the referendum vote on the proposed medical-dental school, Doctors Henry B. Decker and Reuben Sharp urged efforts to develop a favorable response by the voters. It was announced that familiarizing data would shortly be distributed to all members in order that they may be informed on this vital issue.

FREDERICK W. DURHAM, M.D.
Reporter

Hudson

The annual meeting of *Hudson County Medical Society*, terminating the administrative year, was held at the Jersey City Medical Center, on May 4. Dr. Joseph P. Donnelly presided.

Elected to office for the administrative year of 1954-1955 were the following:

President—Dr. Edward G. Waters, *President-Elect*—Dr. Sigmund C. Braunstein, *Vice-President*—Dr. John E. Annitto, *Secretary*—Dr. Arthur P. Trehwella, *Treasurer*—Dr. Charles E. Rosen, *Reporter*—Dr. Stephen A. Mickewich.

Guest speaker was Mr. Eugene J. McCloskey, Regional Manager of Hospital Service and Medical-Surgical Plans of New Jersey. Mr. McCloskey gave a detailed explanation of Blue Cross and Blue Shield enrollment and benefits.

STEPHEN A. MICKEWICH, M.D.
Reporter

Mercer

Under the chairmanship of Dr. Joshua N. Zimskind, its president, the *Mercer County Medical Society* held a regular meeting Wednesday evening, October 13, 1954.

Dr. Lowell Erf, Assistant Professor of Medicine, Jefferson Medical College, spoke upon "Radio Isotopes."

Committee reports were presented, and programs for the coming year discussed.

Doctors Winslow J. Bashe, Jr.; Joseph M. Fiorello; John D. Franzoni; Marvin Friedmann; George Hafitz; Milton G. Marlon; Robert E. Pur-

cell; and William B. Tomlinson were elected to active membership.

Doctors Lawrence I. Bonin; James D. Doriety; Alphonse P. Palmieri; David W. Parsons; Percy H. Wood, Jr. and Edward L. Zega were elected associate members.

Refreshments were served at the conclusion of the meeting by the following members of the Woman's Auxiliary to the Mercer County Medical Society: Mrs. Luman H. Tenney and Mrs. J. Thomas James, of Princeton; also Mrs. R. John Cottone; Mrs. Sydney G. Fine; and Mrs. George A. Corio; of Trenton.

HENRY L. DREZZNER, M.D.
Reporter

Monmouth

The Fifth Annual Summer Dinner-Dance of the *Monmouth County Medical Society* was held at the Berkeley-Carteret Hotel, Asbury Park, on September 18 under the general chairmanship of Dr. Martin Rush. The occasion was well attended and proved to be one of the outstanding social functions of the year.

A panel discussion on "The Doctor and the Law" was featured as the scientific session at the regular meeting of the County Society on September 22 at Monmouth Memorial Hospital. Members of the panel were: Mr. George R. Sommer, Newark attorney, who spoke on "Malpractice;" Dr. Daniel Featherston, whose subject was "Doctor-Lawyer Relationship"; and Hon. Harry Medinets, who discussed "The Doctor in Compensation Court."

The business meeting was conducted by Dr. Howard Pieper, the president. The following were elected to full membership: Drs. Joseph R. Ackerman, Asbury Park; Murray Kessler and Charles Zukaukas of Long Branch; Charles F. Laycock, Long Branch, accepted for membership by transfer from Luzerne County Medical Society of Pennsylvania. Elected to Associate Membership were: Drs. Joseph L. Gluck, Middletown; Lorenzo W. Harris and Collins H. Robinson of Asbury Park; Robert H. Saber, Loch Arbour; and Pascal Federici, Long Branch. Elected to Courtesy Membership was Dr. William F. Wacker, Spring Lake.

DONALD W. BOWNE, M.D.
Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held in the form of an installation dinner, introducing Dr. Leopold E. Thron, the new President, to the Society. Dr. Thron reviewed the accomplishments of the Society in the immediate past, advocating streamlining the work of the Welfare Council by having the committees participate more by studying and making recommendations on matters referred to them. The meeting was held at the Alexander Hamilton Hotel on Wednesday, September 15.

The following guests of the Society addressed the gathering briefly: Dr. Vincent P. Butler, president-elect of Medical Society of New Jersey; Richard I. Nevin, executive officer of Medical Society of New Jersey; Joseph D. J. Gourley, representing Lester F. Titus, Mayor of Paterson. Other guests included Rabbi Arthur T. Buch, who gave the invocation, Dr. John W. Surgent, Mayor of Clifton, Edward B. Haines of the Evening News, Paterson, Allen W. Smith of the Herald-News, Passaic. Dr. Thron presented Dr. Fortuin with a gavel set in appreciation of his services during the past year and Dr. Fortuin acknowledged, with thanks, this gift and also thanked the members for having conferred the office on him.

A short business session was held, during which the following was elected to Active membership: Dr. William B. Deyo, Paterson. Elected to Associate membership were Doctors John J. Bowe, Oradell; Carmine D. Diorio, Paterson; Edward C. Bressler and Saul Sigendorf, Passaic.

Dr. John A. Ianacone, Co-Chairman of the Dinner, then introduced the speaker, Richard B. Cattell, M.D., Director of The Lahey Clinic, Boston, Mass. Dr. Cattell's topic was "Surgical Diseases of the Pancreas" and his talk was given with illustrations by slides. A question period followed.

DAVID B. LEVINE, M.D.
Reporter

Salem

Dr. Frank Winters presented to the *Salem County Medical Society* at their September 18 meeting, a paper on "Intestinal Obstruction."

Dr. Charles B. Norton, the president, called the meeting to order at 4:30 p.m. It was announced that an unlicensed practitioner in Penns Grove has been fined. Dr. Norton gave a report on the Welfare Committee. Dr. Hunt transferred his membership to Essex county. Dr. Norton asked for a more active county-wide public relations program. Abuse of the week-end "covering systems" in various towns was discussed. It was announced that the Delaware Sub-Depot of the Raritan Arsenal in Penns-Grove, want a part-time physician to cover their hospital. Dr. Lipkin was named to spear-head the Diabetes Detection Drive.

The treasurer announced that all except one of the members had his dues paid up to date. Meeting adjourned to dinner at 5:45 p.m.

CHARLES E. GILPATRICK, M.D.
Reporter

Somerset

On October 14, 1954 the *Somerset County Medical Society* held its annual dinner-dance at the Twin-Brooks Country Club, Watchung. Following the

dinner Dr. M. E. Tolomeo, president, turned the meeting over to the toastmaster, Dr. George A. Glass. Dr. Emerson F. Hird was honored by the Society for his many years service to his community and the Society. Dr. Vincent P. Butler, president-elect of The Medical Society of New Jersey, brought greetings from the State Society and spoke in honor of Dr. Hird. Following short talks by several members of the County Society, Dr. Glass presented Dr. Hird with an engraved tray as a token of the Society's esteem and respect.

At a brief business meeting prior to the dinner, Drs. Maxwell Borow of Bound Brook, Joseph Phillips of Somerville, and Theodore Frankle of Somerville were elected members.

C. S. McKINLEY, M.D.

Reporter

Union

The regular meeting of the *Union County Medical Society* was held on September 15, at the White Laboratories, Kenilworth.

The evening was devoted to business matters and election of new members.

The meeting was first addressed by Dr. Elton W. Lance, President of The Medical Society of New Jersey. He discussed several projects of interest to the State Society and answered questions concerning the status of the contemplated Medical and Dental School.

Mrs. Roy T. Forsberg, the president of the Union County Woman's Auxiliary then spoke on their program for the coming year.

A progress report about permanent headquarters for the society was given by Dr. Emanuel Satulsky,

chairman of the Building Committee. It was voted to conduct a complete poll of all members as to their views on this subject.

Four candidates were elected to membership in the society: Drs. Gardiner C. Bennett, Summit; Burton M. Cohen, Roselle; Alvin J. Kahn, Elizabeth; and Sheldon Fox, Elizabeth.

A collation was served at the end of the meeting.

MERTON L. GRISWOLD, JR., M.D.

Reporter

New Jersey Orthopedic Society

At its annual meeting on October 16, 1954, Dr. John J. Flanagan was elected president of the *New Jersey Orthopedic Society*. Dr. Arthur Thurm was named secretary and Dr. Harold Hansen, treasurer. The undersigned was elected president-elect.

The meeting was held at the Kessler Institute in West Orange. Eight papers were presented on many facets of orthopedics including skin coverage for adherent scars, post-traumatic Charcot disease, surgery for tibial plateau fractures, degenerative arthritis, the use of braces in athetoid types of cerebral palsy and slipped femoral epiphysis. There was also a moving picture film on the diagnostic possibilities of pneumo-arthrography.

Participants included Doctors Amster, Ein, Fettel, Gelb, Keats, Laverne, Maxwell, Peterson, Rechtman, Ruoff, Shands, Sperling and Willner.

Members, their wives, and other guests were entertained at a dinner at Mayfair Farms after the meeting.

WILLIAM KRUGER, M.D.

President-Elect

The Myth of "Athlete's Heart"

The common impression appears to be false that athletes develop enlarged hearts and have a tendency to die young of heart disease. Dr. Thomas K. Cureton of the University of Illinois, has found that the middle age deterioration of champion athletes was not due to earlier, excessive athletic activity. Rather, it is due to subsequent excesses in eating, drinking, and smoking. The champions who kept active have been found to be physically superior to the average middle-aged man.*

Cureton traveled throughout Europe, giving about 128 physiologic tests to 55 former champion athletes. Results were compared with those of identical tests given to non-athletic middle-aged and young men. The com-

parison revealed that the former champion has less "bay window," better feet, stronger hands, and a more efficient heart and blood circulation. Psychologically and physiologically, he is more ready for action, and has better tolerance of stress. He is also stronger and has better muscular endurance.

Cureton believes that appropriate exercise is safe and beneficial for middle-aged men who desire to recondition themselves. It appears that a regular program of physical exercise would lengthen the life-span and decrease deaths from heart disease.

*Van de Water, M.: Athletes have good hearts, *Sc. News Letter* 66:10 (July 3) 1954.

Annual Report Reviews Committee

This is a new venture on the part of the State Auxiliary. This procedure, we hope will eliminate much of the duplication in obtaining information from County Chairmen. State Chairmen who desire certain data may glean such information from the questionnaire instead of calling County Chairmen. They also may obtain action taken on programs suggested by the State Chairmen.

The Annual Report Reviews Committee have compiled a questionnaire for County Presidents listing the essential material required to compile Annual Reports to the State Auxiliary.

Presidents will not be required to submit written reports. They will be expected to present oral reports giving the highlights of the work accomplished during the year at the Convention, and again at the regular meetings in Trenton.

County Chairmen will not be called upon for written reports. We respectfully request that you share the task of collecting the information for County Presidents' reports with your Executive Board and County Chairmen.

Have your Secretary fill in the questionnaire which will be sent at intervals. Please be sure to include all information with the questionnaire. If you have a fund raising project or a public relations meeting be sure to include all the details. Write on paper size 8½ by 11 so that all records will be uniform.

Any publicity such as newspaper clippings would be very beneficial to the committee. Here are the personnel of the committee:

ANNUAL REPORT REVIEWS COMMITTEE

Mrs. Harry E. DiGiacomo—Regional Chairman for the northern counties of Hudson, Passaic, Essex, Bergen, Warren and Somerset—195 Hunterdon Street, Newark.

Mrs. Edward MacDonald—Regional Chairman for the central counties of Union, Middlesex, Mercer, Hunterdon, Monmouth and Ocean—719 Locust Street, Roselle Park.

Mrs. Kenneth E. Corson—Regional Chairman for the southern counties of Cape May, Salem, Cumberland, Atlantic, Burlington and Gloucester—5 So. Myrtle Street, Vineland.

MRS. DON A. EPLER
State Chairman

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Why We Became Doctors. Edited by Noah D. Fabricant, M.D., pp. 182, New York, Grune and Stratton, 1954. (\$3.75)

In this interesting collection of essays and excerpts, Dr. Fabricant lets fifty well known doctors and ex-doctors explain *Why We Became Doctors*. This diverse group includes doctors of today and from the past. Most have distinguished themselves by professional achievements in medicine. Some won greater fame in other fields.

As the contributors to this volume tell of the motivations that prompted them to choose medicine, it becomes apparent that doctors are often hard put to identify their own professional incentives. Love for their fellow man, the fascination of natural or medical science, family tradition and respectability,

or an adequate means of support appear among the motives listed by these physicians.

Distinguished living doctors (including Walter Alvarez, Arnold Gesell and Evarts Graham) offer reasons for choosing medicine as a career—along with other outstanding physicians such as Walter Cannon, George Crile, Sigmund Freud and Hugh Young. The major achievements of each of the fifty contributors are described in concise biographic sketches.

An especially interesting group are the physicians who have made notable contributions to literature. From New Jersey comes William Carlos Williams, pediatrician at Rutherford, who ranks high among contemporary poets. Other literary physicians who tell why they became doctors include

such well-known authors as A. J. Cronin, W. Somerset Maugham and Albert Schweitzer.

Concluding a brief foreword to this very readable book, the editor states that it "is intended not only for doctors, medical students, and the many thousands of young men and women who eagerly look forward to a career in medicine, but also for the vast numbers of general readers everywhere who would like to know why and how their doctors came to be what they are." In *Why We Became Doctors*, Dr. Fabricant has assembled a fascinating collection of answers to this intriguing question.

FRED B. ROGERS, M.D.

Low Back Pain and Sciatica. By L. T. Palumbo, M.D. Pp. 97. Phila., J. B. Lippincott Co., 1954. (\$3.00)

The readers of this pocket-sized opus, will no doubt, carry away with them these ringing words, which are directly quoted from the opening sentence of the introduction—"Oh, my aching back." This miniature book attempts (in vain) to cover in a few paragraphs the diagnosis and treatment of one of man's most baffling and stubborn ailments. "Anatomic considerations" are neatly written off in two "meatless" pages (pocket-sized). There are two redeeming features of this work, however. First, is an excellent collection of copies of radiographs of the spine, and poignant photographs of muscle-strengthening exercises for backache victims. Second, there is a bibliography of 122 words on the subject from an unusually diverse and geographically dispersed group of medical journals. This publication can be recommended only to those medical students, students of nursing, and general practitioners who are comforted by the contemplation of learning all there is to know about back pain and sciatica in a pony edition.

SIDNEY KEATS, M.D.

The Study of the Brain. By H. S. Rubinstein, M.D. Pp. 208. 150 illustrations. New York 1954. Grune and Stratton. (\$9.50)

The clinical and physiologic features of neuroanatomy are well correlated with the purely descriptive aspects in this somewhat high-priced little volume. As a dissection manual it is hard to use, because the student has to shuttle constantly between the instructions in one chapter, the cross references in another and the illustrations in the back of the book. A few of the illustrations are excellent. Most of them are too small to permit adequate detail. The phylogenetic and embryonic aspects of brain anatomy are well covered. A bibliography of 150 references attests to the author's studiousness. The anatomic descriptions are vivid, but reading is somewhat slowed down by the constant references to illustrative plates that may be a hundred pages away. Particularly valuable is the way in which clinical symptoms are coordinated with anatomic lesions.

HERBERT BOEHM, M.D.

Alcoholism. By Jackson A. Smith, M.D. 72 pp. Philadelphia, J. B. Lippincott Co., 1954. (\$3.00)

This little book on alcoholism is just that—a 72-page superficial review of a vast problem. Alcoholics Anonymous, psychotherapy, Antabuse®, the aversion treatment and diet therapy are all touched upon. The new approach to acute alcoholism with the use of adrenocortical extracts is also mentioned briefly.

This compendium, however, does serve a definite purpose. It is easily read in one or two hours and acquaints the general practitioner and internist with one approach to a problem which he had usually studiously avoided. The book is too brief, but in parts it should serve to generate interest and make the physician search for more information.

One reads this abridgement of what should have been a longer treatise, always hoping that the next page will present a little more meat from which one might obtain some educational nourishment. This reviewer at least, after having finished, walked away from the table a little hungry. I felt that a little entree, such as a discussion of the importance of the problem and the selection of patients, plus a little dessert consisting of controlled studies relative to results of therapy, would have made the meal more satisfying.

MARVIN C. BECKER, M.D.

Manual of Antibiotics. Edited by Henry Welch, Ph.D. Medical Encyclopedia Inc., 30 E. 60 St., New York City. Sponsored by American Pharmaceutical Association, Washington, D. C. 1954. Pp. 87. (\$2.50)

It will surprise practically nobody to learn that for some antibiotics, there are 36 different trade names for the same drug. No doctor can remember all the trade names, still less the relative composition of any particular brand. Thus, everybody knows that "Combiotic" is the Pfizer trade name for penicillin-procaine-dihydrostreptomycin combination. But if you can't get this product, do you know that you *can* get this combination of drugs by calling for Syncrobin (Schenley), Dicrystin (Squibb), Penstrep (Merck) and so on, for a dozen others? Here's where this little book comes to your rescue. It lists them alphabetically from bacitracin to viomycin. It shows the composition and trade names. Then it indexes all the trade names alphabetically from Abbotcillin (Abbott, natch!) to Wycillin (Wyeth, of course). After that comes a dictionary of generic names, and then a list of manufacturers giving their addresses.

While \$2.50 may seem like a high price for an 87-page manual, the fact is that with this manual you can find the trade-name if you know the generic name, find the composition if you know the trade-name, and so on. In this antibiotic age it is a reliable guide through a new semantic jungle.

If you don't prescribe antibiotics, you don't need this manual. But who doesn't prescribe antibiotics?

VICTOR HUBERMAN, M.D.

TUBERCULOSIS *Abstracts*

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Isolating the Recalcitrants

By *Roberts Davies, M.D., NTA Bulletin, June, 1954.*

During the past five years Firland Sanatorium in Seattle, Washington, has had an unusual and perhaps unique experience in treating tuberculosis in a large number of persons comprising one of the most unfortunate segments of society—vagrants and chronic alcoholics. This discussion is an attempt to share the experience with others who may face similar problems. It is by no means a blueprint for action, since the staff of Firland Sanatorium does not believe that the best answer to any of the problems encountered is known at this time.

Adequate Beds Available

The situation in the state of Washington has been unusual in that since 1947 in our city, county, and state we have had more beds for the treatment of tuberculosis than have been needed. In the second place, and perhaps largely because there has been an adequate number of beds, the state and local health officers have been zealous in their attempts to isolate every individual known to have infectious tuberculosis and to find the unknowns as rapidly as possible. A city-wide mass x-ray survey in 1948 included the Skid Row area and for several years the Seattle-King County Health Department has x-rayed each new admission to the King County Jail and to the Alcoholic Rehabilitation Center. This survey has recently been extended to the Seattle City Jail.

Locked Ward Necessary

The policy of enforced isolation has necessitated a locked ward which is a part of the hospital and

to which patients are admitted by order of local health officers from anywhere in the state. An occasional patient is admitted on parole from one of the state penal institutions or mental hospitals for treatment of a tuberculosis lesion that cannot be treated in the referring institution. But the great majority of admissions to the locked ward are unemployed or very irregularly employed chronic alcoholics from the metropolitan area.

The first detention facility was a large open ward, but numerous difficulties, ranging from fights between patients to arson and mass escape, have taught that such an arrangement was impractical. There is now a 52-bed ward consisting entirely of single rooms, except for two double rooms in the small and separate area for women patients. There are double sets of locked doors to the outside and windows are covered by heavy screens. All of the rooms can be locked individually. Almost all the rooms have furniture like that in the other rooms in the hospital. A few have only concrete blocks on which a mattress can be placed and have doors which are much heavier than the others. These rooms are reserved for patients who present an unusual risk of suicide, assault, or destruction of property. The whole ward is painted in light colors and is physically as attractive as any other ward in the hospital.

Recreation Facilities Furnished

Except for the maximum security rooms, patients' doors are locked only at night. Visiting between patients is permitted but congregation of large groups is discouraged. Reading material, radios, and television sets are permitted as on any other ward. Occupational therapy which does not

require dangerous instruments, such as knives, is encouraged. The facilities of the Departments of Social Service, Rehabilitation, and Education are furnished as on any other ward, and the services of chaplains and psychiatrists are available. The decreased emphasis on bed rest has created a need for more recreational facilities and a recreation room is now being provided. Visitors from outside the hospital are permitted, but only at one end of the ward, where the visitor is separated from the patient by a heavy fine mesh screen. Patients from the other wards are not permitted to visit patients in the locked ward except in an emergency.

The patients in the locked ward are not permitted to have money or valuables. These are kept for them and they may make purchases by written order on their accounts in the hospital business office. Their mail is opened and read and any packages are opened and inspected in order to prevent narcotics or other undesirable material reaching the patients.

Punishment Not the Purpose

Although there is forced confinement, punishment is no part of the purpose of this program and that fact is emphasized to both patients and employees. The locked ward has only two purposes. These are closely related. The first is to isolate from the public those few patients with infectious tuberculosis who will not stay in a tuberculosis hospital unless they are locked in and who cannot or will not isolate themselves outside the hospital. The second purpose is to protect the other patients of the hospital from disturbance, chiefly from drunkenness, on the part of those few patients who cannot observe the usual standards of conduct.

The average patient who is admitted to the locked ward stays about two weeks and is then transferred to an open ward of the hospital. If he leaves the hospital without permission or becomes disturbing to others, usually because of drinking, he is readmitted to the locked ward for perhaps a month.

On the third admission he will probably stay three months. On the fourth admission he may stay six months or until he is eligible for discharge from the hospital.

The great majority of patients who are admitted to the locked ward are not very troublesome. As a result of the aggressive program of tuberculosis control, from 200 to 300 chronic alcoholic patients are constantly in the hospital but the census on the locked ward is usually about 30.

Short-Term Results Good

The short-term results of tuberculosis treatment in this group of patients is extraordinarily good. Alcoholism and inadequate diet have greatly lowered their resistance to tuberculosis and when these conditions are corrected they respond, sometimes almost miraculously, to proper treatment.

The long-term results of treatment of tuberculosis and of efforts directed toward general rehabilitation are discouraging. The results in treating alcoholism in persons who wish to continue to drink heavily are no better than those reported by others. While a few men have actually been rehabilitated, the majority return to their old pattern of life on discharge and the tuberculosis relapse rate is high. Another possible factor in relapse is a high proportion of refusals of surgery by these men who have a life-long pattern of attempting to avoid the unpleasant aspects of reality.

Altogether this program seems worthwhile. It protects the community from a great many sources of infection. It provides care and treatment for a great many men who need it badly.

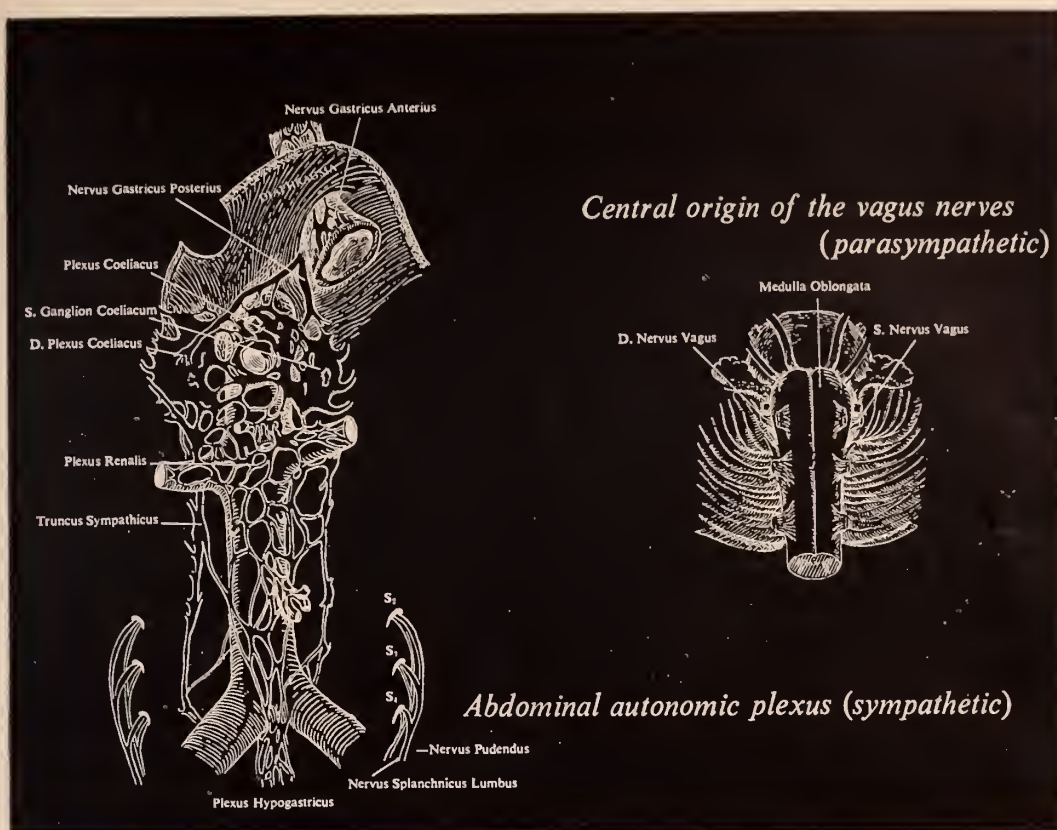
It may be objected by some that one provides a doubtful service if it must be given under lock and key. Certainly, the patients often complain bitterly about being deprived of their liberty and about everything else connected with their treatment. But rather frequently they ask to be kept on the locked ward when they are eligible for transfer to some other part of the hospital. If they run away from the hospital, they often return voluntarily after a short fling. If they do not return, they usually are arrested for drunkenness or by some means arrange matters so that they are certain to be brought back. They very rarely leave the state or make any real effort to escape return to the hospital. Their actions speak louder than their words.

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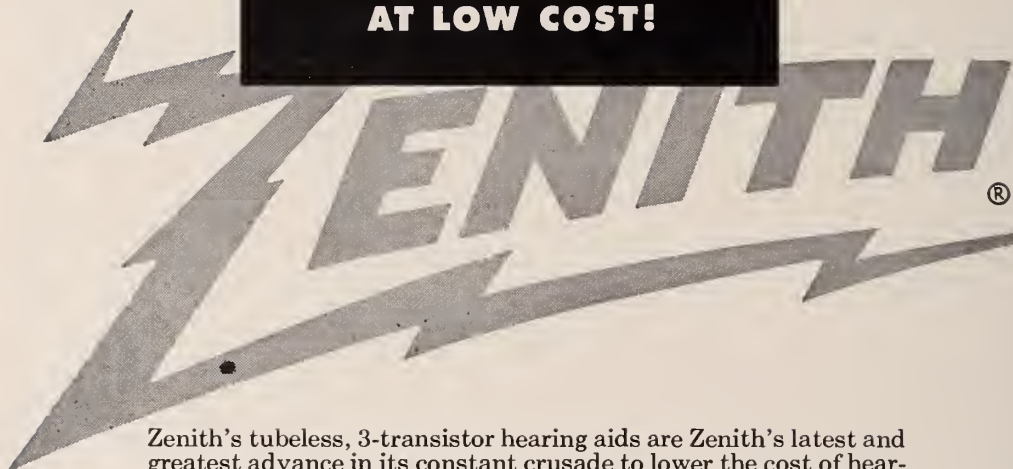
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1. Zupko, A. G.: Pharmacology and the General Practitioner, GP 7:55 (March) 1953.

2. McHardy, G. G., and Others: Clinical Evaluation of Methantheline (Banthine) Bromide in Gastroenterology, J.A.M.A. 147:1620 (Dec. 22) 1951.

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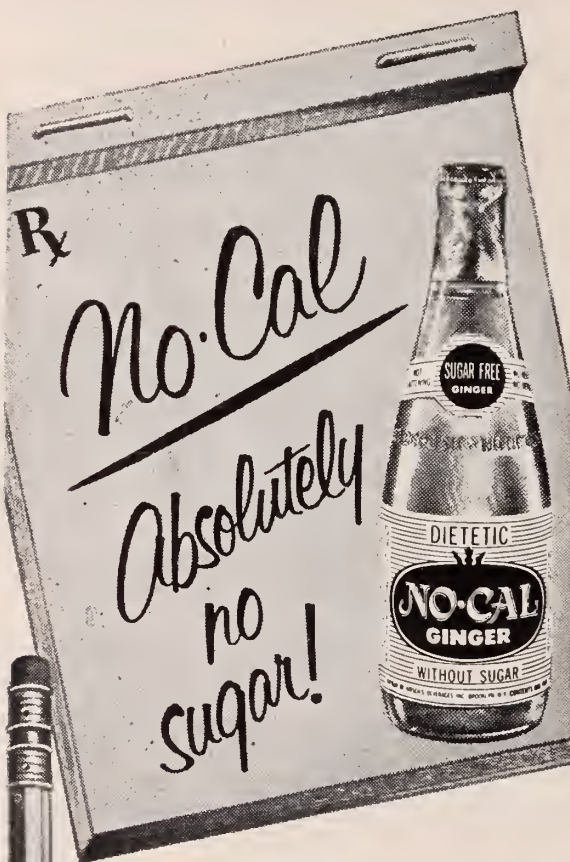
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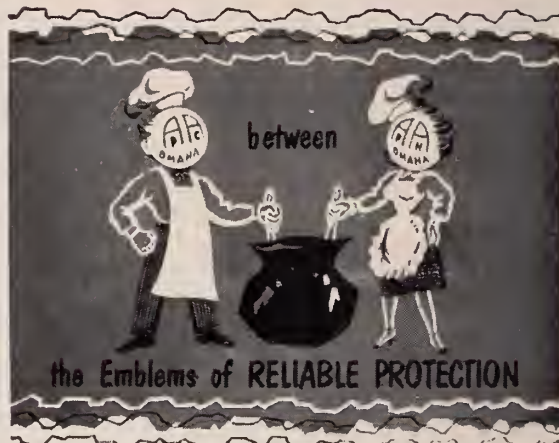
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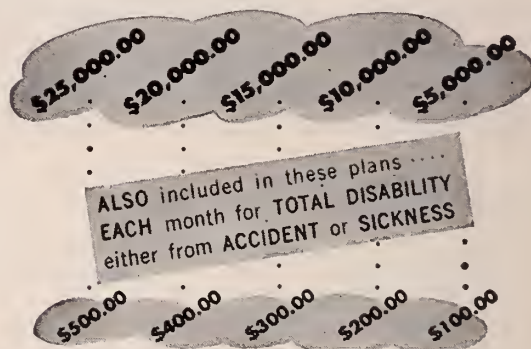
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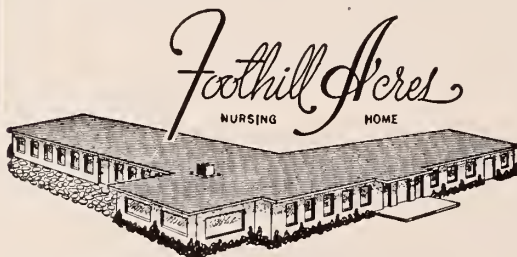
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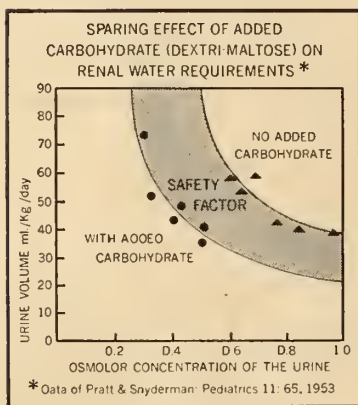
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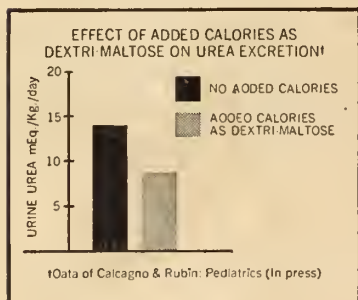
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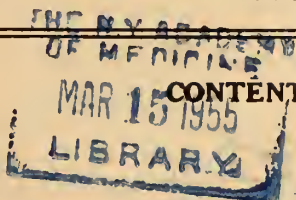
THE MEDICAL SOCIETY OF NEW JERSEY

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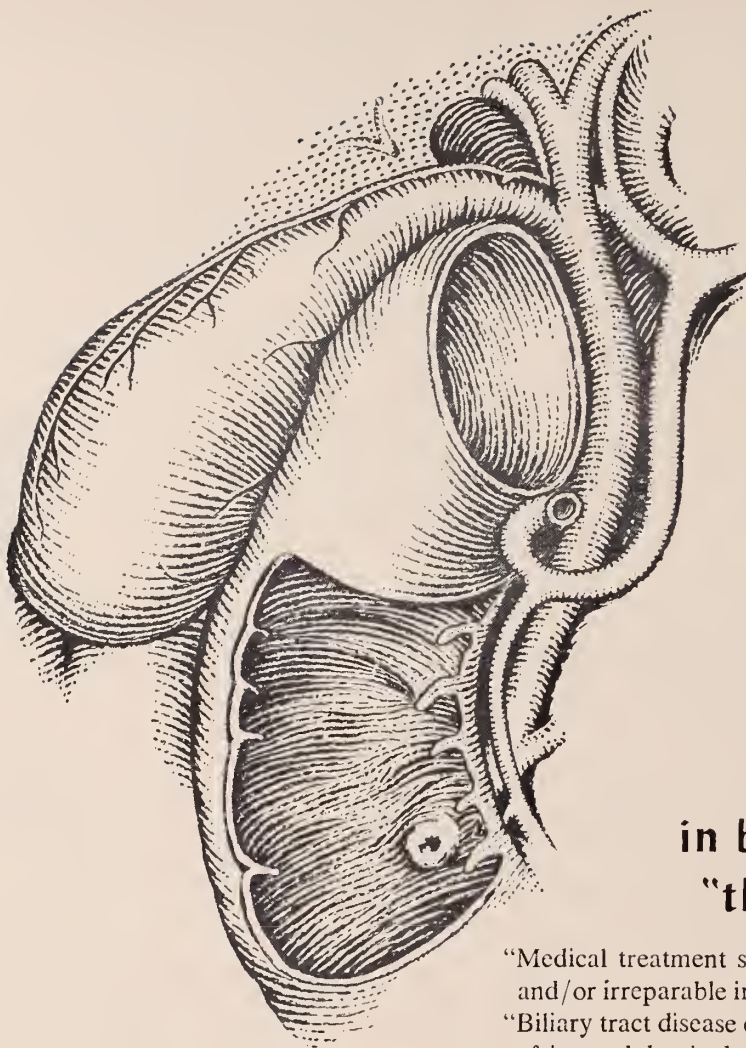
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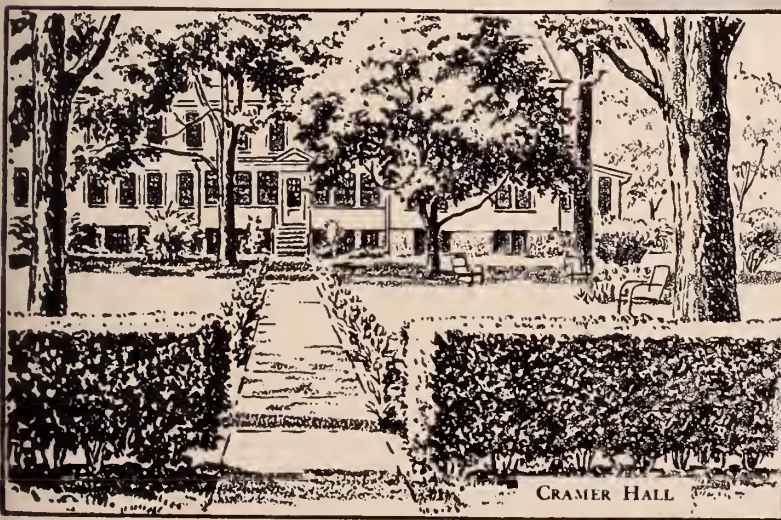
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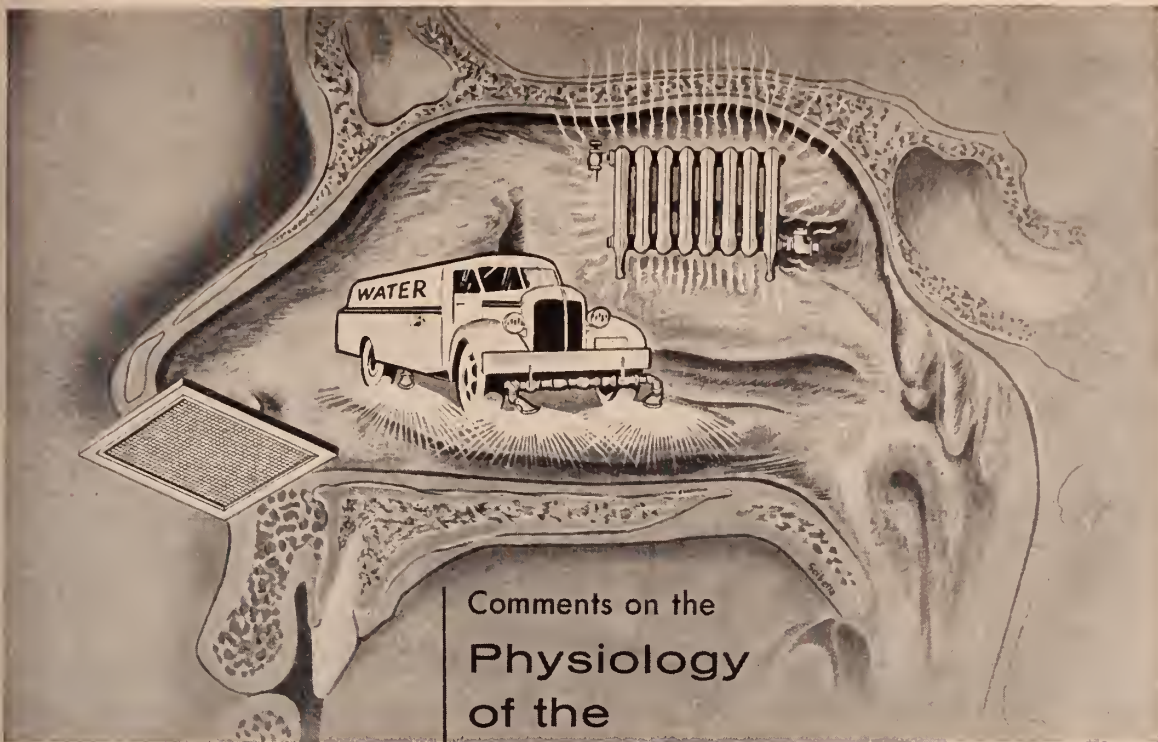
We gratefully acknowledge the advice and co-operation of many physicians in helping us to plan and supply a SUPERIOR SERVICE.

Washed Separately • Dried Separately • Packed Separately

- The container we furnish for used diapers sprinkles its soiled contents with an efficient antiseptic solution whenever the container lid is opened and closed.
- All plant operations are carefully supervised. A chemical check is continuously made, and bacteria colony counts of the diapers are run.
- A modern tested diaper supply service for our customer's exclusive use.



Safe! Individual! Dependable!



Comments on the
Physiology
of the
Upper Respiratory
Tract

THE NASAL CAVITY:

The main functions of the nasal cavity are conditioning and exchanging air between the atmosphere and the lungs, as well as smelling. Gross impurities are removed by the fine nostril hairs, and finer impurities are enveloped in the mucous secretion of the intranasal lining and carried away by ciliary action. The air is warmed to a degree approaching body temperature and humidified. About 500 cc. of air are taken in during an ordinary inspiration, totaling 12,000,000 cc. daily.

In the common cold . . . when hypersecretion and mucosal swelling interfere with the normal aeration pattern, when abnormal mouth breathing is resorted to as a distress measure, relief can be obtained promptly with topical application of Neo-Synephrine hydrochloride. This potent vasoconstrictor is usually well tolerated — produces practically no sting or irritation on application to mucous membranes — even in infants.

NEO-SYNEPHRINE® hydrochloride



Winthrop Stearns INC.
NEW YORK 18, N. Y. WINDSOR, ONT.

0.25% Solution
0.5% Solution
0.25% Solution (Aromatic)
1% Solution
0.5% Jelly
0.25% Emulsion

Nasal Spray

*Plastic, unbreakable,
leakproof squeeze bottle;
delivers fine even mist.*

Neo-Synephrine (brand of phenylephrine), trademark reg. U.S. Pat. Off.

WHEN SYMPTOMS ARE DISTRESSING BUT DISGUISED . . .

"It is strange," Malleson says, "how little clinical recognition" has been given to the "negative behavior" or "endogenous misery" of the woman with endocrine imbalance. Largely accountable for this, of course, is the patient's own reluctance to discuss these symptoms with her physician until she actually suffers from some of the more obvious menopausal symptoms such as hot flushes. Even then she may become so accustomed to her change in feeling she can't remember what it's like to feel well.¹

Changes in the mood pattern are just a few of the many distressing symptoms of declining ovarian function which are so often disguised because they do not always coincide with cessation of menstruation, and at times will occur long before, and even years after. Other good examples are insomnia, headache, easy fatigability, arthralgia — and understandably so, when one considers that the loss of ovarian hormone "withdraws one of the most important metabolic regulators of the organism."²

"Premarin" is a preparation of choice for the replacement of body estrogen. "Premarin" presents a *complete* equine estrogen-complex and all the components of this complex are meticulously preserved in their natural form. This largely explains why "Premarin" not only produces prompt symptomatic relief but also imparts an important "plus" — the distinctive "*sense of well-being*" that patients find so highly gratifying. These benefits of "Premarin" have made it a natural estrogen widely prescribed by physicians . . . and often preferred by patients.

"PREMARIN"®



has no odor
... imparts no odor

Estrogenic Substances (water-soluble), also known as conjugated estrogens (equine), available in both tablet and liquid form

1. Malleson, J.: *Lancet* 2:158 (July 25) 1953. 2. Goldzieher, M. A., and Goldzieher, J. W.: *Endocrine Treatment in General Practice*, New York, Springer Publishing Company, Inc. 1953, p. 23.

NEW YORK, N. Y.



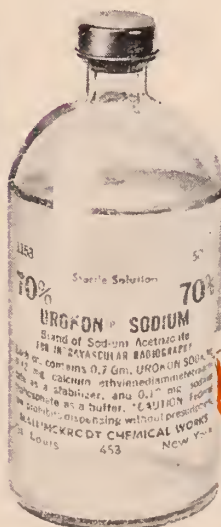
MONTREAL, CANADA

TIMING — *An important factor in making better pyelograms...*

UROKON is excreted more rapidly than any of the other commonly used contrast media. It has been well demonstrated¹ that if X-ray exposures are made routinely at five, ten and fifteen minutes following intravenous injection of Urokon, the "best-filling pyelogram" will appear in one of these three films in nearly all cases.

UROKON 30% ...
for INTRAVENOUS UROGRAPHY,
RETROGRADE PYELOGRAPHY and CHOLANGIOGRAPHY

UROKON 70% ...
for ANGIOCARDIOGRAPHY, CHOLANGIOGRAPHY,
TRANSLUMBAR ARTERIOGRAPHY, NEPHROGRAPHY,
in difficult cases of INTRAVENOUS UROGRAPHY,
and dilution in RETROGRADE PYELOGRAPHY



Urokon Sodium Brand of Sodium Acetizoote

STERILE SOLUTION
UROKON® SODIUM 30% and 70%
...IS QUICK
...ITS RESULTS ARE GRATIFYING
...ITS SIDE REACTIONS ARE SLIGHT

An ideal intravascular contrast medium must be an inert non-toxic material which is non-irritating to tissue, affords a high contrast, is entirely excreted in a reasonable time and produces no ill effects.¹ *Clinical reports indicate that Urokon Sodium closely approaches this definition of the ideal X-ray contrast medium.*

"It has been stated by all observers that Urokon is the most rapidly excreted of all the commonly employed contrast media."¹ Barry and Rose further reported: "In 1025 cases where best filling pyelograms were noted, 951 or 92.8% filled within 15 minutes.... In a busy clinic or office the rapidity with which the medium is concentrated should be of prime importance."

¹Barry, C. N. and Rose, D. K.: Urokon Sodium 70% in Excretory Urography, J. Urol. 69: 849 (1953).

UROKON 30%—25cc ampuls packed in boxes of 1, 5 and 20. Also available in 25cc rubber diaphragm stoppered bottles in same packaging.

UROKON 70%—25cc ampuls packed in boxes of 1, 5 and 20. Also in 50cc rubber diaphragm stoppered bottles in boxes of 1 and 10.

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Karo

helps to support this dramatic growth?

... a carbohydrate of choice in milk
modification for 3 generations

For the newborn

Karo Syrup is a milk additive that is hypoallergenic and bacteria-free. Since it is rich in easily digested dextrose, maltose and dextrans, it provides carbohydrates in directly assimilable form. This minimum demand on the digestive function is important during the first weeks. It makes possible a formula containing 15 calories per ounce even during the period when fat digestion is least efficient.

During the first months

When growth is most rapid, Karo helps to meet the accelerated nutritional demand. It offers in convenient, well tolerated form the carbohydrate additive which is usually prescribed, since milk alone provides just 28% of the optimum 60% carbohydrates. Karo Syrup is also readily available, inexpensive, a miscible liquid that is easy to use. Light and dark Karo are interchangeable in formulas—both yield 60 calories per tablespoon.

For the older infant

Karo eases the transition from formula to whole milk, from liquid to solid foods. The familiar taste of Karo makes whole milk more readily accepted, and many solid foods will be easily introduced into the diet if flavored with a little Karo Syrup. Rapidly assimilable carbohydrate is needed for the rapid metabolism of the small child. Since Karo is low in osmotic pressure, it is non-irritating. It also precludes fermentation because no excess of hydrolized sugars is formed.



Medical Division
CORN PRODUCTS REFINING COMPANY
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"... the gastric secretion is the immediate agent of mucosal tissue digestion.... Opposed to this stands the defensive factor ... the two-component mucous barrier"¹ [the protecting layer of mucus and the mucosal epithelium].



Rotational gastroscopic views showing coating effect 1½ hours after administration of Amphojel.²

Causation — key to treatment in peptic ulcer

Through *topical* action alone, AMPHOJEL contends with the local causes of ulcer—aggressive acidity coupled with impairment of the wall defenses. Providing a dual approach, AMPHOJEL combines two aluminum hydroxide gels, one reactive, one demulcent. The reactive gel combats the attacking factor in ulcer by promptly buffering gastric acid. The demulcent gel promotes healing of the denuded mucosa by forming a viscous, protective coagulum.

AMPHOJEL—nonsystemic, nontoxic—provides time-proved *fundamental* therapy in peptic ulcer.



AMPHOJEL[®]

ALUMINUM HYDROXIDE GEL

Supplied: Liquid, bottles of 12 fluidounces
Tablets, 5 grain, boxes of 30, bottles of 100; and 10 grain, boxes of 60 and 1000

References: 1. Hollander, F.: Arch. Int. Med. 93:107 (Jan.) 1954
2. Deutsch, E.: Scientific Exhibit, Gastroscopy, Clinical Meeting A.M.A., St. Louis, December, 1953



Philadelphia 2, Pa.



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record time

ACHROMYCIN*

Hydrochloride
Tetracycline HCl Lederle

ACHROMYCIN, new broad-spectrum antibiotic, has set an unusual record for rapid acceptance by physicians throughout the country. Within a few months of its introduction, ACHROMYCIN is being widely used in private practice, hospitals and clinics. A number of successful clinical tests have now been completed and are being reported.

ACHROMYCIN has true broad-spectrum activity, effective against Gram-positive and Gram-negative organisms, as well as virus-like and mixed infections.

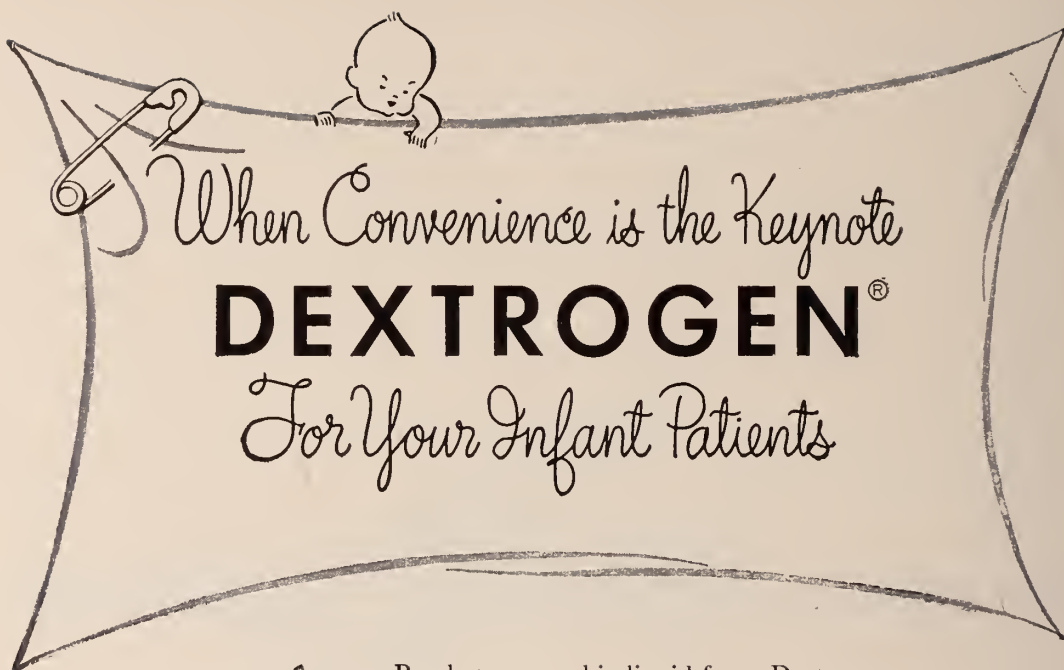
ACHROMYCIN has notable stability, provides prompt diffusion in body tissues and fluids.

ACHROMYCIN has the advantage of minimal side reactions.

LEDERLE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY* Pearl River, New York



*REG. U.S. PAT. OFF.



Ready to use and in liquid form, Dextrogen is a concentrated infant formula, made from whole milk modified with dextrins, maltose, and dextrose. In addition, it is fortified with iron to compensate for the deficiency of this mineral in milk. Diluted with $1\frac{1}{2}$ parts of boiled water,* it yields a mixture containing proteins, fats and carbohydrates in proportions eminently suited to infant feeding. In this dilution it supplies 20 calories per ounce.



The higher protein content of normally diluted Dextrogen—2.2% instead of 1.5% as found in mother's milk—satisfies every known protein need of the rapidly growing infant. Its lower fat content makes for better tolerability and improved digestibility.

Dextrogen serves well whenever artificial feeding is indicated, and is particularly valuable when convenience in formula preparation is desirable.

*Applicable third week and thereafter; 1:3 for first week, 1:2 for second week.

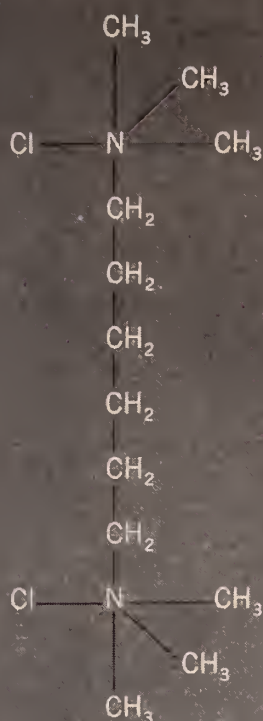
THE NESTLÉ COMPANY, INC.

Professional Products Division
WHITE PLAINS, NEW YORK



**NOTE HOW SIMPLE
TO PREPARE**

All the mother need do is pour the contents of the Dextrogen can into a properly cleaned quart milk bottle, and fill with previously boiled water. Makes 32 oz. of formula, ready to feed.*



"a perfect match"



in the management of hypertension

The potent autonomic ganglionic blocking action of Methium has now been augmented by the mild hypotensive and sedative properties of reserpine. A true synergistic combination, Methium with Reserpine produces "better hemodynamic stability than when either one is used alone."¹ In one series, a greater number of patients obtained adequate blood pressure reduction than from any single drug or combination of drugs previously reported.¹

As blood pressure is reduced — and even without reduction — hypertension symptoms such as headache, retinopathy and palpitation have been alleviated.² Of special significance, a satisfactory response has been achieved with less than half the usual dosage requirements for Methium.² As a result, "the occurrence and

intensity of physiologic side effects were markedly reduced and were minimal and of benign nature."²

Because of the potency of Methium, careful use is, nevertheless, required. Precautions are indicated in the presence of renal, cardiac or cerebral arterial insufficiency. Markedly impaired renal function is usually a contraindication.

Supplied:

Methium 125 with Reserpine — scored tablets containing 125 mg. of Methium and 0.125 mg. of reserpine.

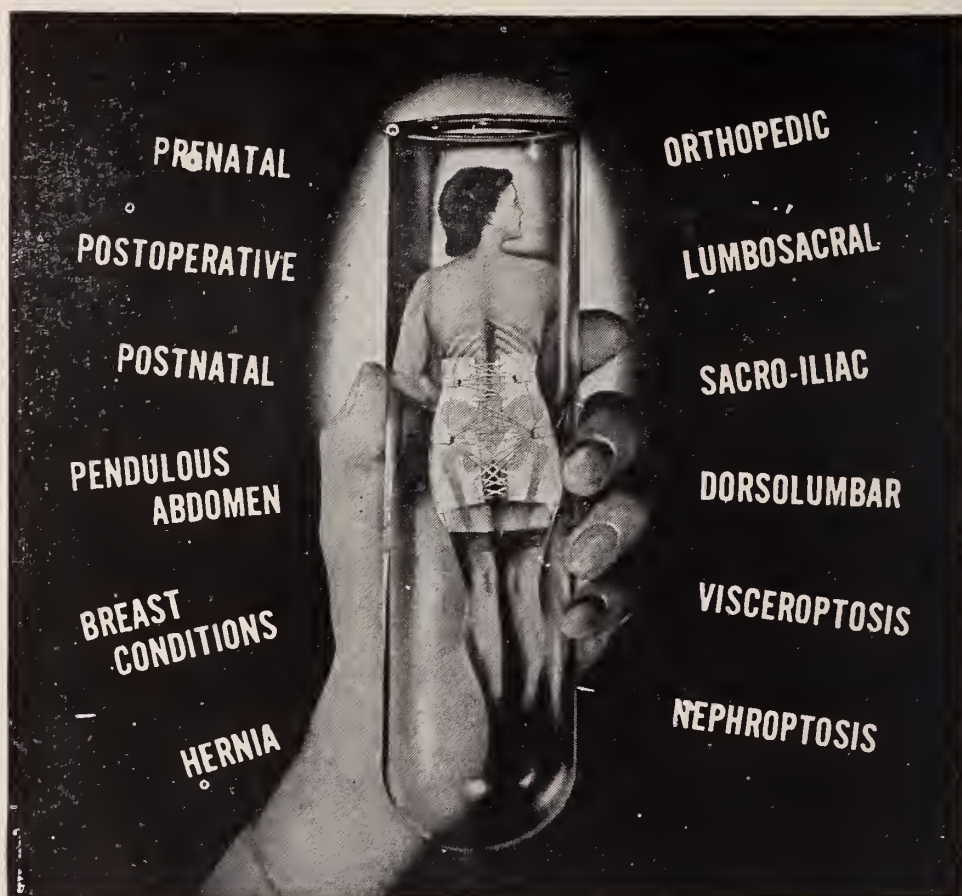
Methium 250 with Reserpine — scored tablets containing 250 mg. of Methium and 0.125 mg. of reserpine.

1. Ford, R. V., and Moyer, J. H.: *Am. Heart J.* 46:754 (Nov.) 1953.
2. Crawley, C. J., *et al.*: *N. Y. State J. Med.* 54:2205 (Aug. 1) 1954.

Methium[®] with Reserpine

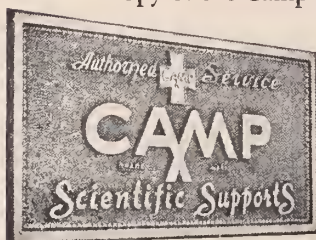
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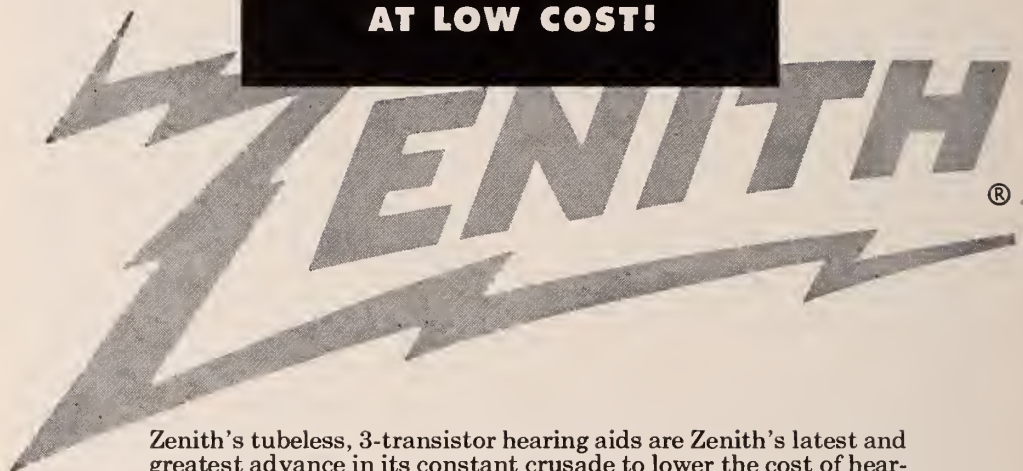
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Any Zenith Hearing Aid Dealer will be glad to give your patients a demonstration of Zenith's famous 3-transistor instruments.

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New tissue-thin *Filmtab* coating (marketed only by Abbott) starts to disintegrate within 30 seconds—makes ERYTHROCIN Stearate available for immediate absorption. Tests show Stearate form definitely protects drug from stomach acids.

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because there's no delay from an enteric coating, patients get high, inhibitory blood levels of ERYTHROCIN *in less than 2 hours*—instead of 4-6 as before. Peak concentration is reached at 4 hours, with significant levels for 8 hours.

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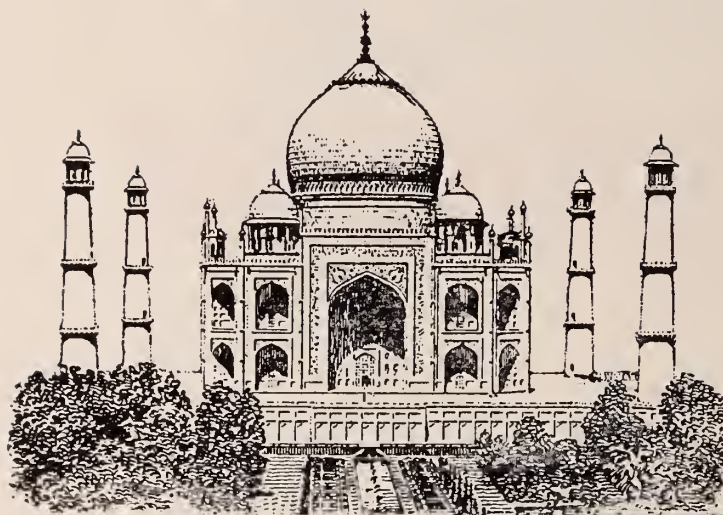
Filmtab ERYTHROCIN Stearate is highly effective against coccic infections . . . and especially useful when the infecting coccus is resistant to other antibiotics. Low in toxicity—it's *less likely to alter normal intestinal flora than most other oral antibiotics*. Conveniently sized (100 and 200 mg.) in bottles of 25 and 100. **Abbott**

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For the Aged and Senile Patient



ORAL *Metrazol*

— to help the geriatric patient with early or advanced signs of mental confusion attain a more optimistic outlook on life, to be more cooperative and alert, often with improvement in appetite and sleep pattern.

Metrazol, a centrally acting stimulant, increases respiratory and circulatory efficiency without over-excitation or hypertensive effect.

Dose: $1\frac{1}{2}$ to 3 grains, 1 or 2 teaspoonfuls Liquidum, or the tablets, every three or four hours.

Metrazol tablets, $1\frac{1}{2}$ grs. (100 mg.) each. Metrazol Liquidum, a wine-like flavored 15 per cent alcoholic elixir containing 100 mg. Metrazol and 1 mg. thiamine HCl per teaspoonful.

Metrazol® brand of pentylenetetrazol, a product of E. Bilhuber, Inc.

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**ORANGE
NEW JERSEY**



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THE COCA-COLA COMPANY



"These tablets
keep the swelling down
all day long."


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BRAND OF CHLORMERODRIN

NORMAL OUTPUT OF SODIUM AND WATER

Individualized daily dosage of **NEOHYDRIN** -- 1 to 6 tablets a day as needed -- prevents the recurrent daily sodium and water reaccumulation which may occur with single-dose diuretics. Arbitrary limitation of dosage or rest periods to forestall refractivity are unnecessary. Therapy with **NEOHYDRIN** need never be interrupted or delayed for therapeutic reasons. Because it curbs sodium retention by inhibiting succinic dehydrogenase in the kidney only, **NEOHYDRIN** does not cause side actions due to widespread enzyme inhibition in other organs.



Prescribe **NEOHYDRIN** in bottles of 50 tablets.

There are 18.3 mg. of 3-chloromercuri-2-methoxy-propylurea in each tablet.

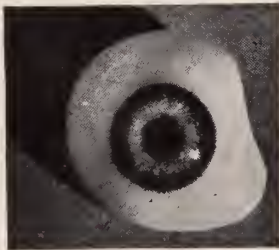


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You can prevent attacks in angina pectoris

Prolonged prophylaxis

Patients receiving Peritrate may obtain practical freedom from anginal attacks for from 4 to 5 hours with each dose. Russek and his colleagues¹ clearly showed that the patient-response to Peritrate was comparable to the effect produced by nitroglycerin... *but* the duration of Peritrate's action was "...considerably more prolonged."

Uncomplicated prophylaxis

Prolonged protection given by Peritrate spares the patient the anxiety of waiting for pain to strike. Besides invaluable psychological support, Peritrate brightens the objective clinical picture

—significant EKG improvement may be seen^{1,2} and nitroglycerin need greatly reduced in most.³ A continuing schedule of only 1-2 tablets four times a day, before meals and at bedtime, will:

1. *reduce the number of attacks in almost 80 per cent of patients^{2,3}*
2. *reduce the severity of attacks which cannot be prevented.*

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References:

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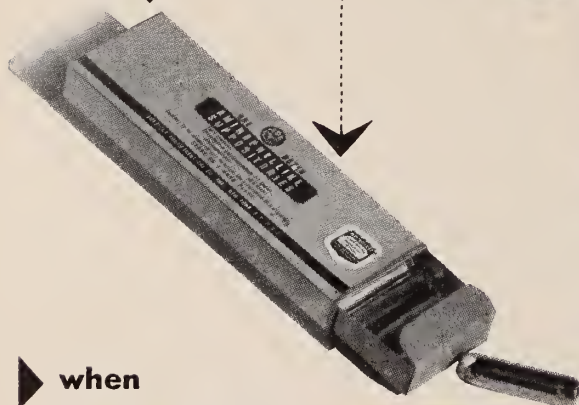
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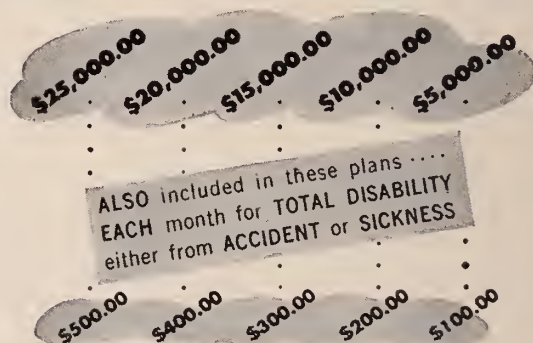
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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Robot Blood Counters

The intern's dream seems about to be realized at last. A Boston company has announced that an automatic and electronic blood counter is now available. Designed by Doctors Richardson, Diamond and Breck of Boston, the new gadget makes and records a complete blood count in less than two minutes. You put a drop of blood in a counting chamber and press some buttons. A built-in microscope with a built-in dark field forms an image of the cells and transmits the image to a built-in photomultiplier. A light beam scans the cells and registers the leucocytes, or the erythrocytes, or both as predetermined by a selector switch. This then feeds its results into a "computer circuit." (I don't know what this is either). The count is then displayed on a calibrated large dial, all ready for report without further conversion or calculation. Accuracy? Plus or minus three per cent.

First they invented the sphygmomanometer. In my father's generation, they scorned M.D.s who couldn't estimate blood pressure by feeling the radial artery, and who had to depend on machinery. Before that, some one invented a glass tube that registered body temperature

and took away the satisfaction of the practitioner who could estimate body temperature within 0.5 degrees just by feeling the forehead. If we trace it back far enough, the culprit who started this destruction of *ars medicinae* was the one who invented the clock (its first use was pulse counting, by the way) and deflated the doctors who could estimate pulse rate by touch.

So now comes the "arithmometer" for counting blood cells. Any day now the electrocardiogram will have a word-writing stylus built in that will write the diagnosis as well as the curve. Electro-encephalography will come next, as they discover the special signature of each neurologic syndrome. Surely there should be something better than boiling for albuminuria. We look for a gadget that will accept the urine, smell it, taste it (for that honey taste in diabetes), measure its acidity and albumin content, and then by ringing bells or stylus-writing come up with a diagnosis. By the next century the doctor's bag will have no stethoscope, sphygmomanometer, percussion hammer or tongue depressor in it. No, all he will need will be a wrench, a pair of pliers and an oil can to keep the machinery in good order.

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Fluorides and Mass Medication

In dismissing the appeal in *de Aryan v. Butler*, the U. S. Supreme Court dispelled the fog of constitutional uncertainty which has surrounded water fluoridation. As in the Kraus case in Cleveland and in the McFarland case in Baltimore, the California petitioner sought to block the fluoridation of San Diego's water supply. His thesis was the familiar one that fluorides were medicines and as a free-born American no one could compel him to take medicine.

Perhaps the best worded reason for dismissing such claims was the one expressed last year by the Court of Common Pleas of Cuyahoga County, Ohio. "The right of an individual to treat one's own health" said this court in the Kraus case "must yield to the common good, where a state . . . enacts a public health measure necessary for the promotion of the health of a substantial segment of its population."

While crack-pottism seems to have been

dominant in these petitions, the basic issue is a serious and sober one. How far can the State go in forcing a citizen to take measures for his own health? This has been the arena for many battles—vaccination, for instance, isolation hospitals, report of venereal disease. The answers show a certain consistency. When the individual's freedom would impair the health of others (as in allowing a patient with contagious disease to walk freely in the crowd), the individual's rights must be abrogated. When an innocent child or incompetent adult is the victim of his health fallacy, then his right to entertain such notions must also be suspended. Freedom is a precious heritage, but the rights of thousands of others cannot be jeopardized to protect the license of a few. Our society has brought us many benefits, flowing from the fact that we live together and work together. We cannot ask for these benefits without paying the modest price of subordinating personal whim to public good.

Little Abner Gets Medical Care

Every medical society likes to talk about its duty to operate in the public interest. And most medical societies do, indeed, take an active and unselfish part in community health planning. Few, however, go as far as the Tennessee Medical Association did last year. It was discovered that within a hundred miles of the world's greatest gold depository, there was a community that not only had no hospitals: it had no doctors. Disease rates and infant mortality rates in this simulacrum of Dogpatch were about the highest in Tennessee. And Tennessee rates are *not* the lowest in the country. Here is where the Tennessee Medical Association came in. They established and financed a special Foundation. The Foundation brought in a full-time physician, a young doc-

tor of unquestioned competence. The Foundation built, equipped and opened a clinic for him. The Medical Association arranged for a panel of circuit riding specialists to visit the community at regular intervals and to serve on call for emergencies. By now other community agencies are pitching in to lighten the burden on the Medical Association. This is one of the most vigorous examples of medical society leadership in recent years. There is much talk about how much better these things can be done by private enterprise and private agencies than by government bureaux. Much talk, but little doing. Here is one medical society that has shown the way. Perhaps it has set a pattern.

GEORGE T. PACK, M.D.

New York, N. Y.

The Dilemma of Gastric Cancer*

Although still a formidable, and usually fatal disease, the gastric cancer picture is not at all hopeless. In this classical review of the problem, a distinguished surgeon states the case for radical surgery and shows how five-year survival rates can approach the 50 per cent mark.

I HAVE witnessed the evolution in treatment of gastric cancer through a quarter of a century, which permits one to have a perspective as to the accomplishments of the past and the anticipations of the future. Twenty-five years ago, it was commonly said that any surgeon who removed a cancer of the stomach had no thought but to kill two at a single blow; one was the patient and the other was his, the surgeon's, reputation.

We have seen this concept change so that now gastric cancer is diagnosed earlier, and is being properly attacked in almost every hospital throughout the United States. The great problem, of course, has been to recognize this insidious disease at the time when surgical treatment becomes possible.

Some fifteen years ago, Dr. Edward Livingston and I reviewed all of the world statistics on end results in the treatment of gastric cancer. We collected and analyzed these figures from all countries and from every major medical center in the United States. At that time the prospect for the gastric cancer patient in the country as a whole was indeed most dismal. Less than 50 per cent of those with gastric cancer were even admitted to hospitals for an attempt at treatment. Of those admitted to the

institution, only half of them underwent a surgical experience. Of those operated on, only half in the very best institutions had their cancers of the stomach resected.

The average operative mortality in the United States at that time varied between 22 to 28 per cent. Bear in mind this percentage figure for surgical fatality was for subtotal or partial gastrectomy. Among the resection survivors who had to live without evidence of residual cancer for the three, five and ten-year periods of definitive cure, the results were so bad that less than four out of 100 original patients with gastric cancer had any prospect of surviving for the five-year period.

Now, fifteen years later the cure rates have greatly improved. In my opinion it has been the efforts of the American Cancer Society which have contributed most to improvement of these figures. This has been due to education of the laymen, so that with persistent "indigestion" in middle age, they are no longer content to treat themselves with advertised medicines. They demand of their family doctor more than the administration of alkalies and diet for persistent "indigestion," until their security has been assured by a preliminary x-ray examination.

An analysis of responsibility for delay in the treatment of cancer (based over a ten-year

*Delivered at the Annual Meeting of the New Jersey Cancer Society, Atlantic City, Oct. 25, 1953.

period) showed a progressive improvement on the part of the lay public in avoiding this delay. Unfortunately, there has *not* been an equally great improvement on the part of the physician first consulted. More recently, Dr. Guy Robbins and I reviewed the culpability for delay in diagnosis and the institution of proper treatment in physicians who themselves had cancer, many of whom had cancer of the stomach. Sad to relate, *for the physician who is a cancer patient himself, the period of delay between the first symptom and the time he went to the doctor was as great as it was for the lay public.* Also, in his selection of the initial consultant for the treatment of his gastric complaint, he perhaps did not exercise any better judgment than a layman because the consultant was comparably as guilty of procrastination as the physicians first consulted by the non-professional patient.

So it is time for the medical profession as well as the public to awaken to the menace of "chronic indigestion." It may herald a lethal disease.

Efforts to establish an earlier diagnosis have been partly successful. One method has been the selection of certain key centers for pilot studies and to subject every adult over the age of 40 who participates in this study to a routine gastrointestinal x-ray series. These selected people relate no history of "indigestion," because it was important to learn how many Americans over 40 years of age *without* antecedent "indigestion," had an unsuspected gastric cancer and, if so, could it be recognized? And, if diagnosed and properly removed, what would be the prospect of salvage?

This experimental survey has been conducted in several places throughout the country. Results have been more or less uniform. One of every 800 adults (over 40 years of age) routinely subjected to a rapid fluoroscopic study of the stomach supplemented by gastrointestinal x-ray series when necessary, was found to have an unsuspected gastric cancer. Faced with the absolute diagnosis, most of them agreed to an operative removal of the cancer.

Is this a practical trend? It is *not* practical to use this system universally throughout our

country in an attempt to reduce the 25,000 to 30,000 deaths of Americans from gastric cancer every year. If roentgenologists were to fluoroscope a patient, let us say, every five minutes throughout the day, and they worked 40 hours a week, and devoted their full time to this effort (bearing in mind that there are 45 million Americans over 40 years of age) and if these studies were repeated every year, it would consume the entire working lives of 1900 roentgenologists. But there are only about 2100 diplomates of the American Board of Radiology. Obviously, the method is not practical and its expense would be prohibitive even at the rate of \$10 an examination. It would then cost \$8000 to discover each gastric cancer. We do not have the funds, the personnel and the equipment to apply this technic as an over-all method. In fact, we should make such examinations every six months, if we expect to detect early gastric cancers.

More than twenty years ago Dr. Harry Hauser, now of Cleveland, was a Fellow in Radiology of the Memorial Hospital and conducted such a pilot survey. In the course of the examination of 100 adult patients who had no "indigestion," he found one patient who had a small polypoid sessile tumor in the stomach. I operated on this man and removed his tumor. Dr. Ewing said it was one of the earliest cancers of the stomach he had seen. This patient is still living and has been well for more than twenty years. In other words, Dr. Hauser's early clinical experiment at least paid off with a long-term salvage of one patient with gastric cancer.

THE "PRECURSOR" GROUPS

SOME hospitals, medical schools and clinics have tried to find certain key types of individuals who could be studied more intensively, because of the possibility that they were "precursor groups" for the development of gastric cancer. Such a "precursor group" includes patients who have pernicious anemia. Another would be those patients with achylia gastrica or atrophic gastritis. A third "precursor group" would be those with benign polypoid tumors of the stomach. In other words, instead of a

routine gastrointestinal examination of all Americans over the age of 40, it has been thought more practical and rewarding to follow, as years go by, every person known to have a gastric polyp, or polyposis, an acidity of the stomach, or a pernicious anemia.

Because patients with pernicious anemia are now being properly treated, they live much longer and for a sufficient time so that the occurrence of gastric cancer in this group is now found to be much greater than in any other group of Americans. Statistical evidence furnished by Dr. Owen Wangenstein and Dr. Leo Rigler suggests that out of every 100 patients with pernicious anemia, the prospect is that eight will ultimately develop cancer of the stomach.

In our Gastric Service at the Memorial Hospital, we have followed for many years all patients who were found to have atrophic gastritis with characteristic anacidity. Although the cancer susceptibility is not as great as in the pernicious anemia group, it appears that one out of 100 such patients followed over the course of years, may be expected to develop gastric cancer.

Consider 800 adults over 40 years of age. How many will be expected to develop gastric carcinoma? Of the 800:

- 1, if the 800 are apparently "normal" adults
 - 8, if they have achylia gastrica, and
 - 64, if they have pernicious anemia.
- are expected to develop gastric cancer.

I shall not dwell upon the controversial subject of the relation of atrophic gastritis to cancer of the stomach; we have differences of opinion even in our own hospital. The relation cannot be proved nor disproved on a statistical basis. In stomachs that have been removed for cancer, atrophic gastritis is not a constant accompaniment; at least, not in a sufficient number of cases to constitute valid statistical evidence. There have been some important and sporadic key cases that seem to point the way. Perhaps more conclusions can be drawn from the study of these specific patients than could be drawn from the group as a whole.

A case in point is worth mentioning in detail. A 70-year old woman, completely asymptomatic, had a routine examination in the detection clinic. Dr. Robert Sherman, roentgenologist to the Memorial Hospital, found a small defect in the gastric shadow. This incident occurred in the course of a pilot study. She was subjected to a subtotal (three-fourths) gastrectomy for this very small lesion. In addition to this one obvious small cancer, examination revealed two others discretely limited to the mucosa, indicating the multicentricity of this neoplastic process. Also in the mucosa were 14 small tiny white *Versé plaques*, not elevated above the level of the mucosa. Microscopic section of these showed independent primary gastric cancers. Sections taken at random throughout the remaining mucosa revealed occasional microscopic *carcinoma in situ*. This patient recovered from the operation and is now living and well, more than five years following the operation. Had she been younger and in good health, an immediate reoperation and completion of a total gastrectomy would have been done. It is incredible that with more than 20 obvious foci of either clinical cancer or *carcinoma in situ* in the surgical specimen, the residual and intact quarter of her stomach would be free of incipient cancer. She and her family are acquainted with her problem and her hazards. Consent for a necropsy has already been secured. None of us knows how long it will take for such cryptic cancers of the stomach to evolve to the stage where they provoke clinical evidence. Perhaps this one key case may contribute such valuable information.

The other so-called precancerous conditions of the stomach are also controversial, *e.g.*, the so-called gastric polyp. Dr. Owen Wangenstein and I hold opposite opinions about the management of the polyp recognized in the stomach. He will not remove these polyps unless some evidence of malignancy is found. He prefers to keep these patients under intermittent observation. Admittedly, it is an interesting clinical experiment to ascertain how long it takes for a polyp, apparently benign, to evolve to the stage of clinical cancer and be recognized as such. I should like to have such information but I cannot conscientiously apply such an experiment to the individual patient. I would rather deprive myself of this knowledge and remove the polyps, because it has been my experience that many of them which we considered preoperatively to be benign proved to be malignant after we had removed them. Anacidity of the stomach is usually present in patients who have gastric polyposis, even if it be a single polyp. We, therefore, cannot make an early diagnosis of malignant

degeneration of a gastric polyp on the basis of such laboratory studies alone.

ULCER AND CANCER

THE perennial question which still seeks an answer is the relation of gastric ulcer to gastric cancer. We must distinguish between ulcer on the stomach side and duodenal ulcer. The latter causes little worry in terms of its relationship to cancer. We have had only a few instances of gastric cancers in patients with coexistent duodenal ulcer. On the other hand, it may be extremely difficult to establish a differential diagnosis between a benign gastric ulcer and ulcero-cancer. No single criterion is proof of the malignancy of any one lesion. When the surgeon has the specimen in his hand, opens it and views the ulcer, and when the pathologist grossly examines it, the error in diagnosis is roughly about 15 per cent. Of 100 such cases, diagnosed by the pathologist on gross examination as benign gastric ulcer, subsequent microscopic examination reveals cancer in the wall, in as many as 15 per cent of specimens. The operative mortality for resection in patients with ulcer of the stomach is obviously much less than 15 per cent. This offers a cogent argument for preferring surgical treatment to prolonged medical therapy.

We may compromise by a therapeutic trial in the treatment of these ulcers on the gastric side. But it is not enough if, under medical treatment, the ulcers diminish in size, the patient's symptoms improve or disappear and the individual gains weight. We have seen these changes occur with patients who had ulcerative cancer. One patient gained 40 pounds in weight while under medical treatment of an ulcero-cancer. We insist that the ulcers *completely* disappear with no perceptible rigidity of the gastric wall. We are constantly reducing the interval of time allotted for such treatment before instituting surgical resection.

It is an important but academic question whether a benign gastric ulcer ever becomes malignant. But it is of paramount importance to the individual patient to know if his ulcer is benign or malignant. The presence or absence of hydrochloric acid, the locations of the

ulcers in the stomach, the age of the individual in whom the ulcer occurs, the size of the ulcer, the symptom complex and other factors may be used collectively but not specifically to arrive at a presumptive diagnosis, for example, ulcers on the greater curvature almost always are malignant. These laboratory and clinical data taken together influence us in deciding whether or not to treat a given gastric ulcer by conservative therapy.

SURGICAL APPROACH

THERE has been a change in our surgical attack on gastric cancer since the early days. This change is comparable to our attitude and methodology in the evolution of therapy for breast cancer. In the early days surgeons performed a simple mastectomy for cancer of the breast. Now, the classical radical mastectomy is extended to remove the internal mammary chain of nodes and even prophylactically the opposite breast, because of the increasing prevalence of bilateral mammary cancer in these people who are living longer. Such is the case with cancer of the stomach.

The type of operation has undergone a comparable transformation from a simple pylorotomy in the post-Billroth years, to subtotal gastrectomy comprising the major portion of the stomach. Now the adequate operation is interpreted as including a *total* gastrectomy, removing the entire stomach in a high proportion of cases, and in conjunction with the stomach, adjacent organs such as the spleen, tail and body of the pancreas, even the splenic flexure and segments of the transverse colon when implicated, and in some instances the left lobe of the liver, if it be invaded directly by cancer from the lesser curvature of the upper segment of the stomach.

Any conscientious physician, critical of his end results in cancer therapy and who analyzes his figures from year to year, may see them constantly improving but can never be completely satisfied. This dissatisfaction is one of the incentives for attempts to improve the end results, because the treatment of any disease is far from perfect.

Cancers in the upper segment of the stom-

ach (which is about 8 to 10 per cent of the organ involvement) were at one time classified as nonresectable and inoperable. In my early experience, out of compulsion, I treated these cancers by radiation therapy. I reported before an International Congress of Radiology a series of 267 cancers of the gastric cardia that were treated by irradiation with dismal end results. There were a few miracles. Of course, this regional location of cancer now is amenable to surgery. In fact, a higher proportion of resectability obtains for cancers of the upper segment than for cancers of the distal segment which is a strange paradox, indeed. From being inoperable, it is now the most favorable portion of the stomach for surgical attack.

The operation which was formerly a pylorotomy became more radical and thus more adequate through the removal of the perigastric lymph nodes, which necessitated an ablation of the great omentum, a dissection of lymph nodes in the retropyloric groups, an excision of the entire gastrohepatic omentum with contained nodes from the celiac axis down to the duodenum. Yet this still was only a subtotal gastrectomy. This operation was and still is feasible only for cancers in the distal half of the stomach.

Cancers of the proximal segment were removed in earlier years by total gastrectomy or cardiectomy through the abdominal route. Later it was discovered that the operation was technically easier through a combined laparothoracotomy approach. By this procedure, the abdominal incision was extended into the left chest, the diaphragm transected, the lower end of the esophagus and the entire or proximal half of the stomach was removed. The jejunum or distal gastric remnant was then brought up through the chest for anastomosis. This was a great improvement over the previous approach for cancer of the proximal gastric third, but it was not sufficient. The tendency of cancers of this part of the stomach to metastasize to lymph nodes in the hilum of the spleen and along the superior margin of the pancreas, has become generally recognized. When Dr. Douglas Sunderland of the Department of Pathology in the Memorial Hospital,

studied these surgical specimens by clearing them (Spalteholz technic) he found that 40 per cent of the patients with cancers of the proximal gastric third had proved metastases to lymph nodes in these locations. With such indisputable evidence, it became imperative routinely to remove these lymph nodes, draining this portion of the stomach.

Experimental evidence indicated that they would be involved by gastric cancers in this location. If you inject a soluble dye, such as pontamine sky blue, into the normal stomach in the region of the cardia, fundus and lower esophagus, you can see a flow of the blue dye along the previously obscure lymphatic pathways into these lymph nodes. When the same blue dye is injected intramurally into the prepyloric segment of the stomach, its course through the lymphatics is again visualized. It is disconcerting to witness the flow of this blue dye upward into the hepatoduodenal ligaments thence to the portal fissure of the liver in addition to its flow through the lymphatics accompanying the pancreatoduodenal vessels and into lymph nodes situated behind the pancreas, as well as into the conventional pattern of retro- and infrapyloric lymph nodes draining the prepyloric segment. This dramatic observation makes us realize that an adequate surgical attack on cancers of the pyloric antrum would of necessity demand a pancreatoduodenectomy as well as a gastrectomy. At this moment, I have not had the temerity to adopt such a procedure as a routine operation for cancers of the distal segment of the stomach. Therefore, we are continuing to do subtotal gastrectomies in a radical fashion for cancers of the pyloric segment unless these patients have obvious metastases to lymph nodes in the juxta-cardiac location, under which circumstances a total gastrectomy is done. Total gastrectomy is done routinely for all patients who have gastric cancers in the proximal segment of the stomach, for superficial spreading cancers and those of multicentric origin, for diffusely invading or scirrhus carcinomas, and for all patients with gastric lymphosarcoma.

The net result of these new attitudes happily has been an increased resectability for patients coming to us with cancer of the stomach. For-

merly, only a few patients were given an opportunity for cure. Now the operability rate for all applicants to the clinic is about 78 per cent. Resectability rate for all patients is 47 per cent. In abstract, this means that we are able to take out at least half of all cancers of the stomach that we encounter. The figure would be even better were it not for the fact that we still receive and accept many patients with inoperable gastric cancers and with recurrent gastric cancers that have been operated on elsewhere. All of this diminishes our mathematical chance for increasing the resectability rate.

Patients with recurrent gastric cancer, *i.e.*, in the remaining gastric segment, may be offered a second opportunity for cure by an attempt at secondary resection and in a certain proportion of cases they may be salvaged. Even when this operation is safely and technically accomplished, however, the number of long-term cures is dismally few.

One of the most interesting and important surveys done on the Gastric Service, was by Dr. McNeer and Dr. Bowden. They reviewed the incidence of recurrence of gastric cancers in patients who had subtotal gastrectomies in the major hospitals of New York City. The cases selected were those of patients who had subtotal gastrectomies for cancer, who recovered from the operation, were discharged from the hospital, then were readmitted to the institution, died there, and had postmortem examination performed. Through the cooperation of the pathologists in these hospitals, they were able to secure the records of about 100 such patients. The necropsy reports are illuminating: 40 per cent of them had recurrence of the gastric cancer in the proximal gastric stump and 11 per cent had recurrence in the duodenal stump. In other words, *more than 50 per cent of those who had subtotal gastrectomies for cancer in important New York hospitals had recurrences in a part of the gastrointestinal tract which should have been removed at the initial operations.*

This is a very convincing reason for replacing subtotal gastrectomy with total gastrectomy. It is also a good argument for executing a more radical operation if only the subtotal

type of gastrectomy is feasible. The surgeon at the operating table should ascertain, with the cooperation of the pathologist, whether he has cut through viable cancer at the superior and inferior margins of the excision. By using frozen section analysis, the pathologist may inform the surgeon of the presence or absence of microscopic evidence of cancer at the proximal and distal lines of resection. Thus the operator may plan the scope of gastrectomy in the individual case.

200 TOTAL GASTRECTOMIES

Now that the number of our patients who have undergone total gastrectomy is reaching a considerable proportion (200 plus) we are faced with the problem of what to do with people who have had their entire stomach removed. Many have also had adjacent organs excised at the same time. The number of patients who had had total gastrectomy more than ten years ago is not great but it is significant; I have three individuals who are now living and well more than ten years after total gastrectomy for cancer of the stomach. We have many living more than ten years who have had subtotal gastrectomy, and I have two who are living over twenty years following gastrectomy for cancer. The significant conclusion is the proof that people can live for more than ten years without a stomach.

What has happened to these people? Have these three 10-year survivors developed pernicious anemia as was predicted? No, they have not. It has been commonly said that if the stomach is entirely removed and the patients live long enough, primary anemia will supervene because of loss of the intrinsic gastric factor. However, they have *not* developed primary or pernicious anemia. Of course they have received liver and vitamin therapy. Those who have had stomach completely removed have difficulty in utilizing vitamin B₁₂. The administration by mouth of radioactive cobalt-labelled vitamin B₁₂ as a tracer study, results in the excretion of almost the total quantity.

Metabolic studies on these gastrectomized patients more than ten years ago showed that

they seldom gain weight. They remain somewhat undernourished due largely to their low caloric intake. Many of these patients have a "dumping syndrome" which is distressing. Two of the three patients living ten years after total gastrectomy still complain of the dumping syndrome. This syndrome has been studied by a group of investigators at the Memorial Cancer Center and will be reported in detail later. These patients absorb their carbohydrates very fast with resultant hyperglycemia, shock-like syndromes of variable degree, hypopotassemia, electrocardiographic variations and changes in blood volume.

There is a very definite diminution in the amount of external pancreatic secretion in people who have undergone total gastrectomies. Almost all of them have an increased fat content of the stool. Normally one would expect $1\frac{1}{2}$ to 2 Grams of fat in the stool while on the diet we have prescribed. Many of the patients have had 8 to 20, even 28 Grams of fat in the feces. This steatorrhea is not always apparent clinically, but it is chemically evident. The only way we have been able to combat it is to give large doses of pancreatic enzyme. Large quantities of protein in their diet also helps somewhat, perhaps because it calls forth a more abundant pancreatic secretion, with the fat enzymes, and lessens moreover the amount of too quickly absorbed carbohydrate consumed daily.

How can we prevent these nutritional disturbances in people who have no stomach at all? Numerous ingenious plans have been tried. Everyone, it seems, is trying to see what kind of organ he can substitute for the stomach. Many bizarre innovations have developed. One plan is to bring up the entire right half of the colon, and do an anastomosis between the esophagus and the ileum. This uses the right colon as an interposed reservoir and connects it to the duodenum. The claim has been made

that this improves nutrition and eliminates the dumping syndrome. A strip of transverse colon or a strip of jejunum has also been interposed between the esophagus and duodenum. Some surgeons make extra large jejunal pouches. All of these are now being used experimentally in an effort to discover if the loss of the reservoir action of the stomach in itself is mechanically accountable for the distressing symptoms of which so many of these patients complain. They do have an appetite and they do experience hunger.

CONCLUSIONS

EXTENSION of radical surgery in the treatment of gastric cancer will greatly increase the proportion of resection survivors. It will increase even more the prospect of total salvage of patients originally seen, because many of them now are being given an opportunity for cure that did not exist in the past.

Our over-all five-year survival rate for patients undergoing gastrectomy for cancer of the stomach is $34\frac{1}{2}$ per cent. Patients undergoing gastrectomy for cancer which has not metastasized to regional nodes, have a definitive cure rate of 41 per cent. The bulk of these cancers are of histologic grades 3 and 4. If we consider only those resectable gastric cancers of grade 1 and grade 2 (which are certainly in the minority) then the salvage rate approaches 52 per cent.

We anticipate that these figures will improve considerably and that the proportion of patients undergoing gastrectomy and enjoying definitive cures (living and well for more than five years without recurrence in the interval)—based on the total number of patients seen—will be appreciably better than they have been in the past.

MARVIN C. BECKER, M.D.

Newark

The Chronic Alcoholic*

A Modern Approach to Therapy

One of the conditioned reflex methods of treating alcoholism has been found by Dr. Becker, to produce improvement in 67 per cent of his patients. Psychotic, deteriorated and persistently chronic alcoholics were not included in this series. The method used is to condition the patient against alcohol by having him take disulfiram, so that a subsequent dose of alcohol produces an unpleasant cardiovascular reaction. This experience acts as chemical restraint.

ALCOHOLISM is now the number four health problem in the United States. The U.S. Public Health Service reports that alcoholism is 10 per cent more prevalent than tuberculosis, 50 per cent more prevalent than cancer and 225 per cent more prevalent than poliomyelitis. Of the 65 million social drinkers in the United States, 4 million are problem drinkers. The alcoholic loses 25 to 30 working days each year as a result of drinking. On many other days he works at half efficiency. The resultant loss in production is 61 million man days and one billion dollars. The concealed cost of alcoholism is enormous. Rehabilitation of the alcoholics would cost the community less than leaving them untreated and handling them by penal measures. Alcoholism respects and eludes no one. Problem drinkers occur in all walks of life, in every business and profession and at all intelligence levels. Of every seven chronic alcoholics, six are male.¹

It seems to me that the private physician has neglected this problem unnecessarily. Actually it should command his interest for many reasons. Alcoholism is a disease and as such it should be under the control of the physician. We should guide these people and not let them try to work out their own solutions, nor leave

them to their own devices. Some might say that this is strictly a psychiatric problem. They may be correct in many cases. Yet psychiatrists have not tackled this problem wholeheartedly. Even if they did, there are not enough psychiatrists to handle them. I have found that a fair proportion of these chronic alcoholics can be helped by the private physician—family doctor or general practitioner. I am an internist and a cardiologist. Yet I take as much pride and gratification in the rehabilitation of the alcoholic as in the diagnosis of a rare cardiac arrhythmia, incurable diffuse vascular disease, or the treatment of an old patient with coronary artery disease.

CLASSIFICATION

THE World Health Organization² has classified alcoholics as follows: (1) Early alcoholism and alcoholism without gross neur-

*Presented at the 188th Annual Meeting of The Medical Society of New Jersey, May 17, 1954.

1. The Problem Drinker: A Challenge to Industry. The Greater Chicago Industrial Conference on Alcoholism, March 13, 1953.

2. World Health Organization Technical Report Series, No. 48. Expert Committee on Mental Health, Geneva, August 1952.

otic origins; (2) Alcoholism in the middle stage and alcoholism with primary neurotic characteristics. They state that these two classes may be treated in private practice or in an outpatient clinic attached to a private hospital. Contrary to popular belief, most are employed and still support their families. To segregate this group and treat them in mental hospitals would impose unnecessary stigmata upon them and place an added burden on their families. (3) Alcoholism in the chronic stage and alcoholism with psychotic involvements and (4) Alcoholism with apparently irreversible deterioration. Alcoholics with psychotic involvements and those with apparently irreversible deterioration are best handled in mental institutions and are not the subject of this paper.

Historically the approach to the treatment of alcoholism has been diversified. Jails, shelters, mental hospitals and prison-type farms have been used. In this country we saw the rise of the Womens' Christian Temperance Union in 1870, the National Prohibition Party in 1872, the Antisaloon League in 1895, the World League Against Alcoholism in 1919 and finally legislation against alcoholism in 1919 with the Eighteenth Amendment and the Volstead Act. These organizations and legislation pointed up the importance of the alcohol problem. They had one other thing in common—they failed. In general they failed because alcoholism is not a sin or a crime or a weakness of will or a defect in character; nor is effective control by prohibition possible.

Another method used for chronic alcoholism has been the conditioned aversion through the use of ipecac, apomorphine or emetine. This I understand is still being used in some places with the quality of the results depending upon the enthusiasm of the author.

I now present my approach to the selection and therapy of certain chronic alcoholics in private practice. It has been successful in enough cases to make me feel it is worthwhile to present it to this audience.

The selection of patients is important. Those below 55 years of age and in good physical condition do best. There must be sincere motivation. This is a prime requisite. He must

admit that he is an alcoholic and sincerely wants to give up drinking. Someone who is led in by his wife with some misgivings; someone who says "well Doc, I can give it up anytime I want" (although he has a notorious history for years); or someone who says he is not an alcoholic and "just has a few with his friends" (although we know his friends are legion and also live in the neighborhood bar);—these men are not going to be helped until they see the light. Another salient feature in the selection of patients is that they should have no severe neuroses or prepsychotic tendencies. Alcohol is their crutch, that all important fuel, keeping them far enough from reality to maintain an even keel.

BASIC STEPS

THERE are five important steps in the handling of the chronic alcoholic in private practice. *First* a complete examination must be done with cardiac, renal and hepatic studies. I include a chest plate, electrocardiogram and an exercise tolerance test to rule out coronary disease as far as possible. Kidney studies such as the Fishberg Concentration Test, phenol-sulfonethalein test and urea clearance tests are usually sufficient. Total protein, albumin-globulin, cephalin flocculation, thymol turbidity and bromsulphalein retention studies are used for a liver survey.

Second, if during the history and physical examination, I feel that there may be a psychiatric problem, I call for a psychiatric consultation to determine if the patient is severely neurotic or prepsychotic. To handle such a patient and possibly precipitate a psychosis by the removal of alcohol would not be in the realm of the internist or general practitioner of medicine unless he could work hand in hand with the psychiatrist.

Nutritional supplementation such as a high protein, high vitamin and high mineral diet is the *third* essential of the program. It provides for the many deficiencies from which these people may have been suffering due to their previous peculiar liquid diet. Being satisfied in my own mind or receiving a green light from

the psychiatrist I proceed with the *fourth* step in the treatment: the use of disulfiram.†

In 1948 after observing the severe symptoms that followed the ingestion of alcohol in patients taking tetraethylthiuramdisulfide, Jacobsen and Hald³ suggested that this drug might be useful in the treatment of chronic alcoholism. These investigators, associated with Martensen-Larsen and other co-workers,⁴⁻⁸ subsequently reported in some detail the chemistry and pharmacology of this drug and their clinical results. These studies were received with much interest. Clinical investigation spread to other countries. Much work has been done here by hundreds of investigators.

THE DISULFIRAM REGIME

THE action of disulfiram® derives from its property of oversensitizing the body to alcohol. It is an antioxidant in the body with specific action on alcohol and its derivatives. When a person takes disulfiram® and then consumes alcohol, an excess of acetaldehyde is produced in his body. This ushers in a chain of unpleasant and, at times, alarming symptoms. The drug in itself is considered non-toxic. It may be taken for years, although some patients do complain of lethargy and impotence. These symptoms may be of psychogenic origin. They are not common. The lethargy is easily combatted with one of the amphetamine derivatives. The impotence, on detailed history is often found to exist long before the disulfiram® administration. Psychoses have been reported, but chiefly in prepsychotic individuals—this only emphasizes the importance of a sound psychiatric evaluation before initiating therapy.

The drug is taken voluntarily after the patient has been "dry" for about one week. The dose is one Gram the first day and 0.5 Gram thereafter as maintenance. Within a period of five days, the patient is given a test dose with an alcoholic beverage of the patient's choice. It is usually equivalent to one-half ounce of 85 to 100 proof whiskey. This I call a "recognition reaction" because it is supposed to acquaint the patient with the reaction and test

the adequacy of the disulfiram® dosage. It is best done in a hospital with a one day admission but some practitioners do it in the office. I advise against doing it in the office. It is omitted only if the patient is physically unsuitable and if adequate warning is given. Another way of acquainting the patient with the reaction is to have him witness it in another.

The first signs and symptoms begin five minutes after the ingestion of alcohol. First there is flushing of the head and neck, spreading downward, later to cover the entire body. The patient gets to look like a red ripe tomato. The way to remember the reaction is to liken it to a histamine reaction. There is hyperemia of the conjunctivae, dyspnea, hypernea, dizziness, severe headache, tachycardia and a fall in blood pressure. The patient may complain of palpitation, difficulty in breathing and chest pain. He may become nauseated, vomit and fall asleep. More violent reactions may occur.⁹ Today the dosage of disulfiram® and alcohol have been diminished as compared to what the dose was in the early days. Severe reactions are not seen as frequently. The response to similar doses of alcohol in the same patient at different test periods is variable and unpredictable. I use only one test period and thus one "experience session." Others sug-

†Disulfiram, more properly tetra-ethyl-thiuram disulfide is marketed by Ayerst, McKenna and Harrison under the registered trade name of "Antabuse."

3. Hald, J., Jacobsen, E., and Larsen, V.: Sensitizing Effect of Tetraethylthiuramdisulphide. *Acta pharmacol. et toxicol.* 4:285 (1948)

4. Hald, J., and Jacobsen, E.: Sensitizing the Organism to Alcohol. *Lancet* 2:1001 (1948)

5. Asmussen, E., Hald, J., Jacobsen, E., and Jorgensen, G.: Effect of Tetraethylthiuramdisulphide and Alcohol on Respiration and Circulation. *Acta pharmacol. et toxicol.* 4:297 (1948)

6. Hald, J., and Jacobsen, E.: Formation of Acetaldehyde After Ingestion of Tetraethylthiuramdisulphide. *Acta pharmacol. et toxicol.* 4:305 (1948)

7. Larsen, V.: Effect on Experimental Animals of tetraethylthiuramdisulphide. *Acta pharmacol. et toxicol.* 4:311 (1948)

8. Asmussen, E., Hald, J., and Larsen, V.: Pharmacologic Action of Acetaldehyde. *Acta pharmacol. et toxicol.* 4:311 (1948)

9. Becker, M. C., and Sugarman, G.: Death Following "Test Drink" of Alcohol in Patients Receiving Antabuse.® *J.A.M.A.* 149:568 (1952)

gest more. The violent reaction may amount to shock.

On rare occasions there may be a delayed reaction. I have seen two such cases. The patient may get over the initial reaction which lasts about 30 minutes. Then, approximately 2 hours later, he may for some unexplained reason develop another severe reaction with recurrence of shock. This must be anticipated in order to avoid unnecessary difficulties.

What may result from these reactions? During the reactions it is not unusual to get electrocardiographic changes with tachycardia, T wave inversions and coronary insufficiency.^{10,11} These may result from the excess of acetaldehyde in the system or may possibly be due to the drop in blood pressure giving coronary insufficiency. Maintained drop in blood pressure is due to lack of vigilance on the part of the physician. These cardiac difficulties explain the importance of a complete cardiovascular survey. Since the material is detoxified in the liver and excreted by the kidney, I insist that these systems be normal before the test dose is given.

How does one combat these reactions? The usual "recognition reaction" is over in about 20 minutes and nothing need be done. In the mild reaction, however, something can be done in terms of suggestions. I usually call for nurses, orderlies and interns to help administer oxygen, intravenouses and hypodermic injections as a method of impressing the patient as to the severity of the reaction which was caused by only a half jigger of liquor. If the reaction is moderately severe with dyspnea and minor cardiac arrhythmias such as ventricular premature contractions, the administration of oxygen is usually sufficient. In severe reactions, I administer 5 per cent glucose in normal saline, fortified with massive doses of ascorbic acid and place the patient on shock blocks. If the response is not prompt and the blood pressure remains low, I add Norepinephrine® to the infusion in order to restore the blood pressure toward normal and obviate coronary insufficiency. Some physicians use intravenous antihistaminics, because the reaction resembles a histamine reaction. These severe reactions may be alarming not

only to the patient but also to the uninitiated physician.

Following the test reaction the patient is maintained on disulfiram® and warned against other reaction producing substances such as paraldehyde and alcohol in any form. Cough mixtures, paregoric, lobster thermidor, rubbing alcohol and even shaving lotion may produce reactions.

He is instructed to carry an *Antabuse*® identification card. This prevents the use of alcohol as a stimulant should he be found ill due to accident or other cause. The usual therapeutic gesture by a stranger, namely, giving a "shot of liquor" to someone who is on *Antabuse*®, might lead to dire consequences.

PSYCHOTHERAPY

THE fifth step in the rehabilitation of the alcoholic in private practice consists of the weekly followup by the private physician for a period of at least 6 months. The patient may be handled individually or in a group and given superficial psychotherapy. It serves to reinforce the patient's motivation, reinstitute his self respect and confidence and diminish his guilt. It sets up a good doctor-patient relationship and provides a strong shoulder for the alcoholic to lean upon. Usually as time goes on the patient swells with pride, as does the physician when they realize that jobs are held permanently, financial difficulties are rectified, family relationships cemented and money is going into the corner bank instead of the corner saloon. In severe cases this followup may best be done by a psychiatrist or lay analyst if the patients can afford them.

Complementary followup by other agencies is another adjunct in therapy that the physician may employ. One might urge the patient to join Alcoholics Anonymous. One might enlist the aid of the family, religious leaders,

10. Macklin, E. A., Sokolow, M., Simon, A., and Schottstaedt, T.: Cardiovascular Complications of Tetraethylthiuramdisulfide Treatment. *J. A. M. A.* 146:1377 (1951)

11. Markham, J. D., and Hoff, E. C.: Toxic Manifestation in the Antabuse® Reaction. *J.A.M.A.* 152:1597 (1953)

social and rehabilitation agencies as further support of the community behind the man who is trying to rehabilitate himself.

RESULTS

MANY reports of Antabuse® therapy have been published. One of the most extensive and, in my opinion, the only really controlled study is that by Hoff and McKeown.¹⁸ They organize their results into five classes, as follows:

- I. Complete abstinence.
- II. One relapse.
- III. Improved, as shown by (a) wider spacing of sprees, (b) happier adjustment at home and in community.
- IV. No improvement.

They compared a group of 560 patients treated with disulfiram† with a group of 232 alcoholics not so treated. The controls and the subjects all received identical therapy except that no Antabuse® was used with the controls. At the end of the study period, 78 per cent of the Antabuse® treated subjects were in classes I, II, or III. But only 48 per cent of the controls were in these "improved" classifications. This difference is greater than could be accounted for by chance. Other authors¹²⁻¹⁷ have reported improvement ratios varying from 43 to 82 per cent.

I treated 36 patients in private practice. Of these, 24 improved to the point of classification in Groups I, II, and III. That is, the improvement ratio was 67 per cent.

Apparently alcoholics between the ages of 40 and 50 do best. Young alcoholics do badly.

Female alcoholics are also extremely difficult because when the female of the species with her usual inhibitions, descends to making a public display of herself and becomes an alcoholic she must be very sick mentally. In general the periodic or "spree drinker" does best. The daily "off the job" drinker has only moderate success. The continual "non-migratory nipper" is a poor candidate. The migratory "skid-row" drinker is hopeless and therapy should not be attempted in private practice.

The treatment of chronic alcoholism in private practice is a neglected, yet fertile field for medical endeavor. It is incumbent upon the private physician to try to rehabilitate some of these alcoholics. It is an alluring part of medical practice, utilizing the acme of therapeutic resourcefulness. If a physician delights in gaining a family's everlasting gratitude (and we all do) here is one field abounding in such pleasures.

12. Brown, C. T., and Knoblock, E. C.: Antabuse® Therapy in the Army. *Armed Forces M. J.* 2:191 (1951)

13. Thimann, J.: Drug Therapies in Alcoholism. *New England J. Med.* 244:939 (1951)

14. Gelbman, F., and Epstein, N. B.: Initial Experience with Antabuse®. *Canad. M. A. J.* 60:549 (1949)

15. Helgeson, C.: Treatment of Alcoholism. *GP* 8:53 (1953)

16. Larimer, R. C.: Treatment of Alcoholism. *J.A.M.A.* 150:79 (1952)

17. Stevenson, C. W., and Wallace, J. A.: Survey of Antabuse® Therapy. *South. M.J.* 46:422 (1953)

18. Hoff, E. C., and McKeown, C. E.: Evaluation of Tetraethylthiuram disulfide in Alcohol Addiction. *Amer. J. Psychiatry* 109:670 (1953)

CARL W. SCHOENAU, M.D.†

Montclair

Carcinoma in a Horseshoe Kidney

A horseshoe kidney is something of a rarity. A carcinoma in a horseshoe kidney is rarer still. Dr. Schoenau reports such a case and comments on the diagnostic and surgical problems it presents. Dr. Schoenau died on November 11.

Horseshoe kidney is an unusual anomaly first described by Vesalius. Hinman¹ found it 80 times in 69,000 autopsies. Judd, Brasch and Scholl² found 17 cases in 2,424 operations on the kidney. Reynolds and Howard³ observed one case in 1,100 autopsies. Young⁴ calculated the incidence as one in 600. Jeck⁵ in 16,735 post mortem examinations found the incidence to be one to 643.

Tumors of the kidney are more common. Bell⁶ reported 149 tumors of the kidney in 20,000 autopsies. Willis⁷ cited 27 cases of renal carcinoma in 1,060 autopsies of people who had died of carcinoma.

Carcinoma in a horseshoe kidney has been reported about 25 times in the last 30 years.

Any of the renal diseases may affect the horseshoe kidney; but the probability of pathologic changes due to the stasis is greater because of impeded drainage of the pelvis. Eisendrath and Rolnick⁸ found 250 reports of operations on horseshoe kidneys. Twenty-one of these were for Rovsing syndrome. Of the other 229 cases, the pathologic changes were, in order of frequency: (1) Nephrolithiasis. (2) Hydronephrosis and Pyelonephrosis. (3) Tuberculosis. (4) Neoplasms and cysts.

Rathbun⁹ in 1924 reviewed 108 surgical cases and the lesions noted in order of frequency were: (1) Calculi; (2) Hydronephrosis; (3) Tuberculosis; (4) Pyonephrosis.

Walters and Priestly¹⁰ in 1932 reported 50 cases which were operated on.

The pre-operative diagnosis of horseshoe kidney and the location of the pathologic lesion in such a kidney is important. In the case below reported, I was prepared to cut the isthmus, ready to look for anomalous vessels and prepared for an anomalous course of the ureter.

†Deceased November 11, 1954.

1. Hinman, Frank: The Principles and Practice of Urology, Philadelphia, Saunders. p. 465 (1933)
2. Judd, Edward S., Brasch, William F., Scholl, Albert J.: Journal of The American Medical Association, 79:146 (1922)
3. Reynolds, Lloyd R., Howard, Nelson J.: Journal of Urology 30:653 (1933)
4. Young, Hugh H.: Practice of Urology. Philadelphia, Saunders, vol. 2 p. 13 (1926)
5. Jeck, Howard S.: Journal of The American Medical Association 99:603 (1932)
6. Bell, Elexious T.: Renal Diseases. Philadelphia, Lea and Febiger p. 421 (1947)
7. Willis, R. A.: Pathology of Tumors. St. Louis, C. V. Mosby p. 456 (1948)
8. Eisendrath, Daniel P. and Rolnick, Harry C.: Urology. Philadelphia, J. B. Lippincott. p. 612 (1938)
9. Rathbun, Nathaniel P.: Journal of Urology, 12:611 (1924)
10. Walters, Woltman, Priestly, Joseph B.: Journal of Urology, 10:276 (1932)

CASE REPORT

This 54 year old male was admitted to the hospital with a complaint of pain in the left flank. The pain was dull and aching. It was not transmitted. He had had gross hematuria for 4 days previously. The bleeding had ceased the day of admission. The following day, he had a gross hematuria again. Urine was now reported as having three plus albumin and "innumerable" red blood cells. A blood non-protein-nitrogen was reported at 50 milligrams per 100 cubic centimeters.

He was physically normal except for some slight costo-vertebral angle tenderness on the left. Neither kidney was palpable. The abdomen was soft. No masses were felt. Blood pressure was 150/80. Chest x-ray was negative. Intravenous pyelogram revealed a negative flat film with prompt function on the right in five minutes. The right pelvis filled in fifteen minutes, and showed an anomalous configuration. The left kidney never filled and function was slow up to thirty minutes.

At retrograde pyelogram the bladder media were bloody. The bladder mucosa was normal. The right ureteral orifice was normal. A clot extruded from the left ureteral orifice. Number 6 french catheters were inserted up each ureter for a distance of 25 centimeters without obstruction. A bloody drip was obtained from the left and clear drip from the right ureter. Indigo carmine appeared on the right in seven minutes and on the left in twenty minutes. The retrograde pyelogram verified the anomalous configuration of the right pelvis. The left pelvis was well outlined close to the mid-line and the calyces were rotated and directed laterally. Just above the upper calyx on the left there was a linear density of dye about which there was a collection of small amounts of dye.

The diagnostic conclusions were: (1) Horseshoe

kidney. (2) Pathologic changes at the upper pole of the left side consistent with degeneration of a new growth.

Operation: At operation the upper pole of the kidney was found to be enlarged, irregular and adherent. The lower pole appeared to be normal kidney tissue. It was freed easily and found in front of the great vessels. A clamp was placed on the pedicle. The isthmus was divided first by taking a wedge shaped piece out of the opposite side. The right kidney was sutured with mattress type sutures and the capsule sutured over this with interrupted sutures. The pedicle was clamped again and cut between the clamps. The proximal end was tied with heavy chromic suture ligatures. The ureter was freed and found to pass over the isthmus. It was clamped and cut, and the distal end was tied. The medial portion of the kidney was then isolated. At the lower portion, a small aberrant vessel was quickly clamped and tied. The kidney was then removed. A Penrose drain was inserted into the wound, which was then closed in the usual manner.

Postoperative course was uneventful. The drain was removed by the fifth day and the patient was discharged from the hospital on the eleventh post-operative day.

The pathologist reported the specimen as a "clear celled papillary adeno-carcinoma" of the kidney.

A two year follow-up examination failed to reveal any evidence of recurrence.

Fused kidney may be the site of any kind of pathology seen in normal kidneys. The pre-operative diagnosis of both fused kidney and the type of pathology may simplify the surgical technic and modify the approach.

93 Union Street

Disease is Indivisible

Various health problems, which seem unrelated, actually are closely related. If the farmers in an area are all sick with malaria at harvest time, famine results. The lowered resistance of the starving population paves the way for more rapid spread of tuberculosis. Both malaria and tuberculosis result in lowered economic standards. Substandard housing and overcrowding follow and in turn contribute

further to the development of tuberculosis. Extensive dental caries will result in malnutrition, which in turn may produce greater susceptibility to tuberculosis . . . the substandard living conditions resulting in part from such diseases cause discontent, frustration and desperation—fertile soil for the growth of communism. James E. Perkins, M.D., NTA Bulletin, Sept., 1954.

FREDERICK C. LICKS, M.D.

South Orange

Tinea Capitis in New Jersey*

Urging that tinea capitis be made a reportable disease, Dr. Licks reviews diagnosis, calls attention to the high frequency of scalp ringworm, and recommends local therapy for a few months before resorting to x-ray epilation.

IN NEW JERSEY, tinea capitis constitutes a major public health problem. Although the disease is highly contagious, it is not reportable. Since it is not reportable, we have no accurate records as to the number of cases, or where they are located. This interferes with prevention and control measures. There is no uniform ruling as to whether an infected child may attend school. Customs vary from one school to another, even in the same school district. Too often, the decision is made by one who can have but little idea of the mycologic and therapeutic problems involved.

The prevalence of tinea capitis is greater than many people realize. Since it is a relatively mild and nonfatal disease, it seldom stirs up public attention unless there is a severe epidemic. Some years ago, one New Jersey community of about 28,000 population had an epidemic of 300 cases. This is mild, however, compared to the 565 cases out of 8,657 school children examined in the Hagerstown, Maryland pandemic of 1944.¹ So far as I know, the severest pandemic ever reported in this part of the world, was in 1950 in the Ontario City of Sault Ste. Marie. Of 5,712 elementary school children, 1,300 had ringworm of the scalp. This amounts to the amazing figure of 23 per cent of the entire child population! In addition there were 150 cases in pre-school children and another 64 among youths and adults. This made a total of 1,414 victims

out of a total population of only 32,000. It could happen to us.

Spectacular as the epidemics are, the everyday run of cases is also important. Every dermatologist usually has one or more cases under treatment. Hospital clinics have more. We have no way of knowing the total number. This is another reason for making tinea capitis a reportable disease. There must be a vast number of undiagnosed cases. In New York City, it was found² that the number of cases in the schools varied directly with the intensity of the search for them.

The types of fungi causing ringworm of the scalp in New Jersey are not too numerous. For several years I have been making mycologic studies on cases in several hospital clinics, in private practice and on referrals from other dermatologists. Most of them turned out to be due to *Microsporon audouinii* with *Microsporon lanosum* a poor second. Included are two cases of *Achorion schoenleini* (favus), one of *Trichophyton ectothrix* on a farm boy infected from a cow, and one of *Microsporon*

*Read May 19, 1954 at the Annual Meeting of The Medical Society of New Jersey.

1. Schwartz, Louis, *et al.*: Control of Ringworm Among School Children. Department of Health, Education and Welfare, Washington, D. C. U. S. Public Health Bulletin 294. Government Printing Office 1953.

2. Mahoney, John F.: Executive Order No. 575 for 1952, City of New York, Sept. 25, 1952.

fulvum. The last two cases were those of Dr. Burrill, who is discussing this paper. The fulvum case was highly inflammatory and cleared up spontaneously only to suffer a recurrence a year later. Again the infection cleared up in a couple of weeks with only boric acid compresses to control the inflammation. One case, caused by *Microsporon lanosum* was observed in the mother of several similarly infected children. Infections due to *Trichophyton tonsurans* (crateriforme) are increasing in the southwestern United States and moving eastward. Some have been observed in this area, especially in New York City.

THE clinical types of tinea capitis seen in New Jersey are few in number. Most are due to *Microsporon audouini* or the human type of fungus. It is called the human type because it is transmitted only from one human to another. The next greatest number are due to *Microsporon lanosum*, the so-called "animal" type. It is also known as *Microsporon canis*, *felineum*, and so on. As the names suggest, the fungus often infects dogs and cats, and in turn, humans. The fungus may then be transmitted to other humans or back to lower animals again. Both fungus infections have many similarities. One or more grayish patches of partial alopecia may appear on the scalp. The areas contain short, broken-off hairs, which are surrounded by a mosaic sheath of spores. It is this mantle of spores which gives a greyish color to the stumps and which fluoresces so brilliantly under filtered ultra-violet radiation. Microscopic examination of infected hairs will identify the fungus as a *Microsporon*. Only cultures can identify the species, whether *audouini* or *lanosum*. Cultured diagnosis is not only definitive but determines the method of treatment as well. Clinically, the *lanosum* infections are more inflammatory and much more likely to produce kerions. A kerion is an inflammatory reaction producing a granuloma from which pus may exude from multiple openings. Because of this inflammatory reaction, the *lanosum* or animal type of infection offers the better prognosis. Occasionally a kerion will be seen in *audouini* infections.

Tinea capitis should be made a reportable disease. In this way we can tell the number of cases and where they are. It would make it possible to check on patients who discontinue treatment and therefore remain a menace to other children. Siblings as well as the infected child's class at school could be checked for infection. This would result in early recognition of new cases and speed their treatment.

The best method of screening cases in a school is by the use of Wood's light or filter. This filter is composed of glass containing sodium barium silicate and nickel oxide. When placed over a source of ultra violet radiation, all wavelengths are screened out except those in the near portion of the ultraviolet part of the spectrum (about 3600 angstrom units). With these rays, hairs infected with the *Microsporon audouini* or *lanosum* fluoresce a bright, yellowish-green color. To a lesser extent, hairs infected with *Achorian schoeleini* (favus) also fluoresce. The hairs infected with the *Trichophytos* fluoresce little or not at all. This makes it important that hairs from every suspicious case be examined microscopically and by cultures before making a negative diagnosis. The operator of the Wood's light should have some training. An inexperienced operator may be confused by other fluorescing substances on the scalp, such as ointments. These may also, at times, serve to disguise the normal fluorescence of the infected hairs themselves.

TREATMENT

TINEA of the scalp due to *Microsporon audouini* remains one of the most difficult of all dermatologic problems. X-ray epilation of the scalp offers the best single method of therapy. In the hands of dermatologists, it has proved a safe and efficient procedure. Cultures should be taken to determine the type infection before the epilating dose is given. Combes and Behrman³ feel that the daily use of green soap followed by ointments containing 5 to 10 per cent sulfur or ammoniated mercury

3. Combes, Frank C. and Behrman, Howard T.: Archives of Dermatology and Syphilology, 57:74 (January 1948).

before and after epilation decreases the proportion of failures, recurrences and spread to other children without any undesirable sequelae. I have observed recurrences following x-ray epilation where local treatment was not used. Thallium acetate will produce epilation but it is unpopular in this country because of its toxicity.

Tinea capitis due to *Microsporon lanosum* (canis) usually responds to local therapy. I am in accord with the many other dermatologists who believe that even the cases due to *Microsporon audouinii* should be treated with local therapy for three months before resorting to x-ray epilation. While some cases are extremely resistant to local treatment, others respond easily and quickly. It is well to give these patients the advantage of a preliminary trial with local medications.

In my hands, the best results were obtained with a salicylanilide in a carbowax base as first used in the Hagerstown epidemic. Later, I found Salundek®, (which is roughly, the salicylanilide plus undecylenic acid and zinc undecylenate) even more effective.

Other necessary measures are the clipping of the hair short and the constant wearing of boilable stocking caps.

Criteria of cure of the fluorescent types of ringworm include failure to find fluorescence on two different occasions 3 weeks apart. For the non-fluorescent types, microscopic and cultural examination of the suspicious material must be made.

Children with tinea capitis should be allowed to go to school. Surveys made 7 months apart in a large school system where infected children were allowed to go to school showed no increase in the infections. It was found that keeping infected children away from school did not eliminate ringworm. In 1943, the New York City Health Department excluded from school all children with tinea capitis. After 9 years of experience, in 1952, it issued a new directive allowing such children to attend classes, while under treatment. Whenever large epidemics are reported, it is usually found that better control and results are obtained by hav-

ing the infected children attend classes. Each school should have a Wood's light and someone trained to use it.⁴ In this way classes may be screened properly and infected children can be detected and sent for treatment.

School nurses should be given additional information regarding the disease, screening methods and prevention of spread. Many do not have this knowledge.

EXCLUSION of infected children has a deleterious effect on the child, his parents and the school system. Often the child is out for long periods. Many are underprivileged children with both parents working. This leaves the child alone to wander around unsupervised. Some of these children have become delinquent. At best, the child merely waits for uninfected school children to come home so that he may play with them. Often the children are left untreated as there is no way to check on them. Most infections occur in the home anyway. It is common for siblings to acquire the infection. Rough play may lead to direct contact, which probably accounts for the greater prevalence of scalp ringworm in boys than girls. The impact on the school system also is great. Some have tried to meet the problem by home teaching or special classes. Neither has met with much success. Often when the teacher gets to a home, the boy is out somewhere. Some schools especially in smaller suburban communities merely exclude the child and make no attempt to continue teaching. Worse, no steps are taken to check his class for other infected children—possibly for the carrier, who gave him the infection in the first place.

Barbers' instruments and the backs of theater seats are often responsible for the spread of infection. Most methods of sterilizing barbers' instruments are either too time-consuming or are actually harmful to the instruments, especially to clippers. How many of us have ever seen a barber actually sterilize an instrument? In the theater, children love to sit way down front looking up at the screen. In this position, they have their knees up with their heads in contact with the back of the seats. Swapping of caps, accidentally or on purpose, also, may spread the infection.

4. Lewis, George M., *et al.*: New York State Journal of Medicine, 44:1327 (June 1944).

CONCLUSIONS

1. Tinea capitis should be made a reportable disease.

2. Children with tinea capitis, who are under treatment, should be allowed to attend school. Spread of infection is more likely to take place outside of school than in it. Stocking caps should be worn.

3. Schools should be supplied with a Wood's light and a trained person to use it. Suspicious, as well as definite cases, should be referred to a dermatologist. These children should present a note from a physician stating that they are under treatment.

4. Barbers should receive instructions from the Board of Health regarding sterilization of instruments. They should be prohibited from cutting the hair of a known or suspected case of tinea capitis.

5. X-ray epilation offers the best available method of treatment for tinea capitis, due to *Microsporon audouinii*; however, many such cases and also those caused by *Microsporon lanosum* (canis) respond well to local therapy and should be so treated for a period of three months before resorting to x-ray epilation. All cases should be cultured.

64 Scotland Road

DISCUSSION

BENJAMIN B. BURRILL, M.D., Montclair, N. J.: It is a pleasure to comment on this paper, for Dr. Licks is especially well fitted to present the subject. Many of us know of his long interest in mycology—in fact it approaches a hobby with him. He corresponds with and exchanges material with universities and mycologists in various parts of the world. Some of us were in his class in mycology at New York University and others have used his extensive collection to further their own knowledge.

Tinea capitis does not have the dramatic and tragic implications of some of the more serious maladies. It seems like a minor threat to the health of the individual. For this reason it is difficult to arouse the general public to its importance. However, it does produce a very real psychic trauma in children excluded for long periods of time from school and from the homes of their playmates. Thus it is of serious concern to those directly involved. Several years ago a brother and sister were presented before a meeting of our Society who had been so excluded for 18 months because of tinea capitis.

If we subscribe to Dr. Licks idea of permitting properly controlled children with tinea capitis to return to school, (and I for one do) then we must be able to assure school authorities and parents that such a course is safe. You and I know that no increase in infection results when the precautions outlined are followed. But we must be prepared to sell this to those who may be hard to convince and rightly so. We are going to be asked what is to keep infection from spreading from school seats if

it can be spread from movie seats. There will be other questions which we must be prepared to answer.

Epilation is a major weapon in treatment here. At present that implies x-ray epilation. This is a controversial subject. The lay public and those physicians who have had little experience with x-ray are fearful of such a procedure. I know several excellent roentgenologists who refuse to do it.

No one is better qualified to perform this service than the dermatologist. Both our training and our natural interest in the disease make it so. Such epilation should be readily available for the resistant cases which Dr. Licks has mentioned. Every dermatologist should have a carefully calibrated unit and a workable technic.

The Wood's lamp in the school is a help but it is not an unmixed blessing. We can correct that by teaching school nurses and sometimes doctors, that all that glitters is not tinea; and conversely that all tinea does not fluoresce.

The dermatologist will do well to do his own cultures. The technic is simple and is one that few laboratories do as well as you can yourself. For example in one clinic, we consistently received negative cultures on clinically positive cases. This was finally explained by the fact that the technician routinely threw out all cultures that showed no growth in three days—standard procedure for bacterial cultures but of no value to us.

Dr. Licks mentioned infection with *Trichophyton tonsurans*. In an active service in New York, we have seen two in the past nine months both in children of Puerto Rican ancestry.

Visual Loss Following Systemic Hemorrhage

Loss of blood in a distant part of the body may cause temporary or prolonged visual loss. Dr. Kline reviews the clinical findings, develops the possible mechanism, outlines preventive and therapeutic measures and reports a case.

VISUAL loss following systemic hemorrhage may be temporary or it may be of longer duration. Temporary visual loss may last only a matter of minutes, or perhaps for an hour. Prognosis is excellent. Normal vision quickly returns. It is probably due to transitory cerebral or retinal ischemia which is quickly and completely compensated.

The second type, the kind reported here, is of a longer duration. In most cases, it is associated with permanent damage to the visual apparatus. It is a well-known, but not a common complication of severe systemic hemorrhage. As an entity, it was first described in the literature by Hippocrates. No mention was made of it in the first text of ophthalmology printed in 1593. Sporadic cases were reported until 1876 when Fries¹ made the first comprehensive survey of the total of 106 cases.

1876 Fries ¹	106 cases
1904 Singer ²	92 cases
1924 Harbridge ⁹	42 cases
1947 Locket ³	47 cases

From these statistics, it would appear that the condition is not at all uncommon. However, if one considers that Haab¹⁰ reported 60,000 cases of hemorrhage without a single instance of visual loss, that DeWecker¹¹ did not observe a single case during the Franco-

Prussian War, and that only two cases were reported during World War I—then one realizes that the condition is rare indeed.

CLINICAL FEATURES

COMMONEST site of the hemorrhage is the gastro-intestinal tract. The uterus is second. Two-thirds of all the cases ever reported were assembled by Singer² who finds that the site of the primary hemorrhage was:

	Per cent
Gastro-intestinal	40
Uterus	32
Blood-letting or leeching*	14
Nose-bleed	7
External trauma	3
Coughing up of blood	1
Urethral	1
	—
	98
Site unknown or record inadequate	2
	—
	100

*In the series reported by Fries,¹ blood-letting (through phlebotomy or application of leeches) accounted for 25 per cent of the cases.

Locket's figures³ computed in 1949 were similar except for a natural decrease in the ratio of blood-letting and leeching.

Very few cases (only 3 per cent) followed injury. The condition is virtually nonexistent in times of war when one would think it would be more prevalent. It usually occurs in patients who have some systemic pathology.

The onset of visual loss following hemorrhage is often delayed. Singer² found that the time lapse between systemic hemorrhage and the onset of visual symptoms was divided as follows:

	Per cent
During the hemorrhage	8
Immediately after	11
Within 12 hours	14
12-48 hours	19
3 to 10 days	40
10 to 14 days	4
18 to 60 days	3
Records inadequate	1

Thus about 30 per cent of the patients complained of visual impairment within 12 hours of the hemorrhage. And the remaining 70 per cent noticed a visual loss anywhere from one day until two weeks following hemorrhage.

Usually both eyes are equally involved. Ter-son,⁴ in reviewing 250 cases, found that 10 per cent were unilateral.

External ocular examination of these patients is generally normal except for decreased pupillary reaction in some cases.

Ophthalmoscopic examination reveals a variety of objective findings. In some cases the fundi may appear completely normal; or there may be moderate attenuation of retinal arterioles. In others may be found the typical picture of occlusion of the central retinal artery. The most common picture seems to be an ischemic optic neuritis. In these cases there is marked attenuation of the retinal arterioles. The optic disc is pale, edematous, and elevated several diopters.

Visual fields show many variations. There may be marked depression with large sector defects, central scotomas, sometimes irregular vertical or horizontal hemianopsia.

Many remain completely blind; however, recovery has occurred, even after visual loss has persisted for several weeks.

PERGENS⁵ (50 cases)

	Per cent
Complete blindness both eyes	36
Blind one eye	18
Marked reduction of vision	18
Complete recovery	8
Inadequate records and follow-up	20

CASE HISTORY

A 37-year old female was admitted to the Cooper Hospital complaining of vaginal bleeding of two days' duration. On the day of admission this had become severe and she had fainted several times. On admission, pulse was 120, the blood pressure 110/70, the red blood count 2,800,000, and the hemoglobin was 49 per cent. A diagnosis of a ruptured right ectopic pregnancy was made and the patient prepared for surgery.

At operation early the next morning under gas-ether anesthesia, this diagnosis was confirmed. During the operation, she was given intravenously 500 cc. of blood and 500 cc. of saline solution. The resident commented at the end of the operation that this patient's blood pressure did not "come up" as rapidly as usual. Blood pressure was 70/40 at the beginning of the operation and remained the same after the operation had been completed—in spite of the intravenous infusion. However, by 15 minutes after the operation, the blood pressure had risen to 120/70.

Upon awakening the next morning, the patient stated that her vision seemed to be impaired. Fundi were not examined. Another half-litre of blood was given. Next day she thought her eyes were better. A blood count showed 58 per cent hemoglobin and 2.9 million erythrocytes. A third 500 cc. blood transfusion was given.

A week later, she was still complaining about her vision. An eye consultation was then obtained. There was pronounced attenuation of the retinal arterioles of both eyes with fairly marked retinal edema, with cherry red spots at both maculae — more marked in the left eye.

She then received intensive vasodilator therapy. This consisted of a grain of papaverine hydrochloride, 25 milligrams of tolazoline hydrochloride (trade-named by Ciba as Priscoline®) four times a day, intravenous injection of 100 milligrams of nicotinic acid twice daily and a left stellate block. The next day she received gr. 1/100 of nitroglycerine (three times a day for two days), while the tolazoline (Priscoline®) was increased to 50 milligrams four times a day.

By the thirteenth postoperative day, much of the retinal edema had subsided and the arterioles no longer showed the marked attenuation. Vision of the right eye was 3/60 (about 5 per cent of normal) and of the left eye 1/60 (about 2 per cent of normal) without correction. At that time, she was put on anticoagulant therapy with the thought that thrombi might be contributing to the visual loss. The following day (14th postoperative day) she was discharged with instructions to take tolazoline (Priscoline®) and methylene hydroxy coumarin. (This latter preparation is called Dicu-

marol® which is the registered collective tradename adopted by the Wisconsin Alumni Research Foundation). She was followed-up in the Ophthalmologic, Gynecologic and Anticoagulant clinics of the Cooper Hospital.

Three weeks after discharge, vision was 75 per cent of normal in the right eye. Three months after onset of her visual loss, the vision of her right eye was 95 per cent of normal, but she was only able to perceive hand movements with the left eye. Thereafter, vision remained fairly constant. Pigmentation about the posterior poles began to develop. Optic nerves showed temporal pallor, more marked on the left.

A year after onset, vision was 98 per cent of normal on the right. On the left she had only the ability to count fingers at two inches (less than 2 per cent of normal). The patient was able to read .37 M print with difficulty with the right eye.

External examination was normal except that the pupil of the left eye appeared to react sluggishly to light.

Media of the right eye were clear. The disc margins were slightly blurred and some temporal pallor was noted. The vessels appeared fairly normal except that a few of the arterioles appeared to have some sheathing in certain areas. Abundant pigmentary and degenerative changes of the retina were present, mostly about the posterior pole and appearing to involve the macula.

On the left eye the media were clear. The fundus changes were similar to those of the right eye except that the temporal pallor of the disc was more marked and the pigmentary changes more abundant.

She had a para-central scotoma in the right eye and a large central scotoma of the left eye.

PATHOGENESIS

AS EARLY as 1899, Holden⁶ studied the ocular changes in exsanguinated dogs. Two days after a single profuse hemorrhage, he removed the eyes and made microscopic sections. He found edema of the nerve-fiber layer and the ganglion cell layers. Other eyes were enucleated two weeks after hemorrhage. Simple edema of the nerve-fiber layer still existed, and there were advanced degenerative changes in many of the ganglion cells and in the medullary sheaths of their axis cylinders throughout the optic nerves, chiasm, and tracts. These changes were uniform in all of several eyes examined. No changes were found in the optic radiations. He concluded that the pathologic finding most characteristic of the retina in exsanguination was degeneration of the retinal ganglion cells. Twenty-one years later Goerlitz⁷ substantiated these findings.

Thus pathologic findings of degeneration of the retinal ganglion cells appear to have adequate proof. However, the cases with visual loss with no fundus changes have not been substantiated by similar findings. By this I mean cases of visual loss *without* optic atrophy—in other words, cases which should be caused by lesions *above* the external geniculate bodies.

MECHANISM

Two problems make the formulation of any theory of mechanism difficult—first the frequent late onset of visual loss, sometimes even several days after the hemorrhage; and second, the apparent restriction of this condition to patients with some physical disease.

Most theories associate a compensatory constriction of the retinal arterioles with the hemorrhage. The resulting anoxemia is supposed to cause degenerative changes in the ganglion cells of the retina.

Duggan⁸ suggested that changes in the eye following severe systemic hemorrhage were similar to those which take place in the body in severe surgical shock. In fact, he called the changes in the eye “shock in miniature.” In surgical shock, there is a generalized vasoconstriction so intense that the capillaries suffer from acute oxygen lack. These capillaries dilate, their permeability increases, and plasma leaks out into the tissues. But, Duggan⁸ postulates, if only a few arterioles show this excessive constriction (for example, the central retinal arteries) then we have “shock in miniature.”

With excessive constriction of the retinal arterioles anoxemia develops and plasma leaks out into the tissues. Consequently, the retinal nerve fibers suffer variable degrees of destruction from this interference with their nutrition. The lesion gives the picture of localized shock—but as Duggan⁸ says, “in contrast to generalized surgical shock, there is a loss of sight rather than a loss of life.”

Most of these patients suffer from some sort of physical illness. The visual loss rarely occurs in a healthy individual suffering hemorrhage due to external trauma. The reason for this is not known. Some have postulated that a

"toxin" acts on the ganglion cells when their nutrition is impaired. Locket,³ however, postulated that these patients generally have anemia, a low serum protein and low body protein reserve; and that with the dilution of the blood following recovery from hemorrhage, the relative blood protein is even further lowered. Therefore, there would develop a decrease in the colloidal osmotic pressure with an increased tendency for the passage of fluids through the capillary walls from the blood to the tissues. This situation would serve to accelerate Duggan's "shock in miniature," and at the same time would explain, at least to a certain extent, the delayed onset of visual loss in some cases.

Other investigators have suggested that the visual loss is due to the development of thrombi secondary to the slowing of the blood stream and the constriction of the arterioles.

With any of these theories, it is still difficult to understand how the visual disturbance can develop in this manner several days after the hemorrhage. The exact mechanism of this is still largely unsettled.

PREVENTION AND TREATMENT

TREATMENT consists principally of stopping the hemorrhage and giving adequate trans-

fusions. Paracentesis of the anterior chamber may increase the blood flow in the retinal arteries. Vasodilators may be of some aid. But if there is reason to believe that they may cause recurrence of the hemorrhage, they can not be used.

Prevention is more important than treatment. Today with the increased number of transfusions following severe systemic hemorrhage, and with more adequate preparation for surgery, the number of cases seems to be showing a relative decrease. This decrease may not be obvious if one takes a cursory look at the statistics. But when one considers two factors, this decrease is more obvious:

- (a) *First*, the tremendous increase in the amount of radical surgery done in recent years.
- (b) *Second*, the fact that in our present era of prolific medical writing, such cases would be more likely to reach the literature than they would have before the turn of the century.

Adequate transfusions and increased pre-operative preparation have slightly lowered the incidence when one would have expected the number of cases to increase. In most cases this visual loss can be avoided. In the future, the incidence will probably decrease even further. But the danger can never be completely eliminated.

524 Cooper Street

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EVELYN PARKER IVEY, M.D.

Morristown

Emotional Factors in Children With Heart Disease*

Though he be ever so expert in interpreting cardiograms and administering medication, the doctor will fail in the care of the cardiac child, unless he sees the emotional problem involved. What the doctor needs is understanding of what illness and disability mean to the child. In this presentation Dr. Ivey paints the need for preventive mental hygiene.

EFFECTIVE treatment of children with heart disease represents a combination of medicine and mental hygiene. It requires the understanding, sympathetic and cooperative teamwork of doctors, nurses, parents, teachers, social workers and community leaders. In this discussion rheumatic fever is taken as an example but the factors involved are applicable to other forms of heart disease.

The emotional needs of the child with heart disease can be best understood by reviewing the needs of all children through their stages of development, the meaning of sickness to children and the special impact upon them of heart disease. An understanding of these factors and a genuine interest in helping the child will enable those taking care of him to render more effective treatment.

Every individual has a primary need for affection, for that sort of attitude that indicates, "I love you for what you are, regardless of what you may do." The second is the need to "belong" to a family and to other groups. Third, comes the ability to receive pleasure from the senses, the enjoyment of sight, touch, taste, smell and sex. Fourth, everyone needs to feel capable of achievement, of being ade-

quate to life's situations. Fifth, he needs to receive recognition from others and believe that others will continue to have confidence in and recognize his achievements.

CLOSELY allied with the last two needs is the importance of an opportunity and ability to share thoughts with an understanding person. When these basic needs are satisfied, the individual is able to weather the storms of life and develop toward maturity. When they are unsatisfied, self-preoccupation persists and precludes full realization of potentialities and service to others.

These emotional needs must be satisfied during the crises of child development which are connected with eating, eliminating, sleeping, obedience, play and independence.

In the first year of life the crises are related primarily to eating and sleeping; in the second year to eating and the beginning of toilet training; in the third year to toilet training and the first play extending beyond the

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child's home; in the fourth year to play and obedience; in the fifth year to obedience and the child's effort to maintain his own identity in an enlarged range of experience.

At about the sixth year, the first clash of wills begins. From 6 to 12 he tends to join cliques, may become secretive and responds to authority outside his home. He begins to accept responsibility. He learns to work for the pleasure of working. He must learn discipline. He must learn discipline in many different forms and in many different activities.

WHEN the child's relationship with his family has been a satisfying one, he is able to meet the crises well, despite some growing pains. Nevertheless, as he develops from a helpless infant to a mature adult some anxiety and hostility are engendered unavoidably. Activity provides wholesome, aggressive release for much of his anxiety and hostility. Children like to explore and to feel strong.

It is thus easy to understand that sickness drastically curtails the child's enjoyment of life. Everyone is sick at some time. It is a life situation which is unavoidable and requires emotional adjustment, as is ably discussed by Josselyn.¹ But for the child, sickness is more than a nuisance; it is entering into a strange and uncomfortable world. He resents it, and may have discomforts which he may fear will never go away. Every sick child needs added comfort and reassurance while his physical needs are tended.

Adults cannot always relieve the pain in children. Yet, as in many other difficult situations in life, children are better able to stand the pain and discomfort of illness if they know adults understand how they feel, will help and stick by them through it all. Adults sometimes have difficulty in reassuring the child because of their own anxiety. They should recognize that when a sick child fusses, demands excessive attention, and becomes more dependent, he is expressing his fear and asking for reassuring help.

1. Josselyn, I.M.: *Emotional Problems of Illness*, Chicago, Science Research Associates, Inc., 1953.

ILLNESS is easier to bear when the child has an understanding, matter-of-fact approach to ill health. Such an attitude enables the child to accept limitation of activity better and to be more cooperative in spite of resentment. This attitude is developed by conditioning the child through simple explanation of illness and of treatment plans for other members of the family, by allowing him to contribute to the care and greater comfort of the sick, and by helping him to accept the unpleasant aspects of treatment as necessary and temporary.

Unhealthy attitudes develop when an adult is disapproving and unsympathetic and makes the sick child feel guilty about causing extra trouble, when adults worry audibly about minor injuries, nag about carelessness with germs, or greet a child with a thermometer when he is merely irritable. Such an attitude makes illness a very disturbing experience.

Another cause of injury to the psyche during illness may be found in the technic of medical treatment. A doctor who concentrates upon the disease without making a friend of the child and preparing him psychologically may arouse fright and anxiety. In theory, practitioners recognize the necessity of treating the child and not the disease, but the pressure of work sometimes changes their perspective as they strive for short cuts.

SKILLFUL and thoughtful history taking, which includes evaluating the child's reaction to his illness, promotes friendly understanding of the child as well as good diagnosis. A doctor who is genuinely interested in the child will weigh his patient's emotional needs, the value of preparation, and of simple interpretation of the diagnostic examination, the findings and the treatment plans. Adults must help the child accept the unpleasant and painful aspects of treatment. The child who is told that an injection will not hurt and finds it does learns only that he cannot trust the adult.

Children should be told in simple terms as much about their illness as they can understand. A handicap cannot be kept from the child, who very well knows something is wrong. The uninformed child may decide that

he has some ominous condition. His imagination will conjure up disturbing explanations. A simple explanation allays anxiety and elicits cooperation. Truthfulness and a realistic attitude in discussing the child's sickness are as important for him as sympathy and genuine concern.

JOSSELYN² points out that in rheumatic fever there are problems which create a situation unique in the medical field. Many of these affect the feeling of security of both the child and the parents. In the acute phase of rheumatic fever the child is extremely uncomfortable. He requires close observation and care, not only because he is acutely ill, but also because of the ever-present threat of heart involvement.

The doctor's relation with the child is difficult for he cannot say, "If you cooperate with us, Johnny, you will soon be out playing football again." He can only say, "If you will help us, we will all work to make you better, and meanwhile, you will learn new things which will be fun."

Since meticulous nursing care and close medical supervision are needed, hospitalization is often indicated, and perhaps for a long period of time. This is hard for a child to accept unless he has been prepared by the explanations of the doctor and his parents. Similarly, later, the child must understand the need for prolonged bedrest in convalescence.

THEREAFTER he resumes activity slowly. If a permanent handicap is present, he must be willing to continue to get much of his gratification in sedentary activity. He must know the dangers involved in not following recommendations. If this is presented casually, without threat or fright, and emphasis is placed on what he *can* do, the child learns to live with his illness in its proper perspective, as part of his life, rather than all of it.

A child with rheumatic fever may be exposed to the death of a friend from the same disease. A child who has learned that one of his friends, seemingly less handicapped than

he, has died through a recurrence of illness, has a graphic demonstration of how thin is the ice upon which he stands. Perhaps he does not reveal his anxiety openly. Instead he becomes irritable and somewhat uncooperative. In this way he is trying to deny the danger to himself—a case of "whistling in the dark." Or, if he is depressed, he may disregard rules because of unconscious suicidal impulses.

There is, however, a brighter aspect to this. Most children who have this disease react with a surprisingly good degree of adjustment. The reason for this may lie in the fact that if the child's background, before the illness developed, has been conducive to mental health, he is able to get adequate reassurance from the nursing care and imposed dependency.

THIS reassurance overcomes his anxiety and helps him accept his reality. The child with good mental health is able to relate to others. This is to his advantage in a hospital. The prolonged separation from his parents is partly alleviated by the child's capacity to accept as parent surrogates the doctors, nurses, teachers and other adults caring for him. Their interest makes it possible for him to shift his dependency from his parents to them. Recreational and occupational outlets compatible with his physical condition and intriguing to his interests enable him to adjust to a new mode of life with adequate substitutes for the pleasures which he has lost.

Nevertheless, emotional disturbances in children with rheumatic fever are more frequent than in the physically well, unselected child, and reveal no characteristic pattern of maladjustment.

An important aspect of treating rheumatic fever is working with the parents. Many parents have anxiety about their children, particularly when heart disease is involved. They are ill-prepared to adopt the calm attitude essential to the child's morale. Doctors can help the parents understand and accept the child's illness. Perhaps, though, the practitioner is

2. Josselyn, I. M.: Emotional Implications of Rheumatic Heart Disease in Children. *Am. J. Orthopsychiat.* 19:4, January, 1949.

too busy to do this. In this case, he is fortunate if he can call upon a competent social worker to help the parents overcome their anxiety. The doctor needs to determine if hospitalization is required and to discuss the possibilities frankly with the parents. In preparation for hospitalization, social work offers invaluable service in assisting the child and his parents by helping them to understand what to expect, and in helping them to accept this positively. If the parents can take care of the child in the home this is a great advantage. Even then, however, parents will need a great deal of professional guidance to help the child adjust to his disease and confinement.

We cannot overestimate the value of keeping a child, even when he is on constant bed-rest, busy with activities and interests commensurate with his abilities and capacities. This has great therapeutic value because it increases satisfactions through achievement and it opens up new roads to satisfaction. There is another advantage: his concentration on activity reduces the chance of excessive day-dreaming, which may trigger off greater anxiety. The resourcefulness of teachers, nurses and parents can be successfully directed toward keeping the child interested.

Adults need to familiarize themselves with certain reactions of sick children. *Tears* are common. Many adults are vaguely uncomfortable when they see children cry. But, as Dunbar³ has put it, tears may be the result of a "mad-sad reaction," the product of anxiety, a mechanism for getting attention, or, (less often) tears many mean only that the child thinks he is expected to cry. Weeping in this last category is of negligible value. The other forms of crying may be helpful because the tears may provide release. The concept of "crying it out" or the permission, "there, there, have a good cry" are not for adult use only. Indeed, the child who wants to cry and cannot, may develop other manifestations which are more difficult to handle, such as hay fever, asthma or frequent colds. One of the common-

est causes for suppressing tears is shame. Children are frequently shamed out of crying not only by other children but also by adults. The "be brave" talk must not be overdone. If a child feels like crying, he should be free to do so while being helped to stop. Frequently a discussion of the reasons for the tears will help stop them, as no one actually likes to cry.

ANYONE taking care of a child who is ill should be able to understand some of the evidences of *regression and anxiety*. He may regress to a greater dependency level and to an earlier mode of expression of tension. This may have to do with eating or sleeping disturbances, elimination disturbances, such as bed-wetting or soiling, or perhaps increased masturbation. These manifestations should be viewed as symptoms of the child's struggle to handle his own anxiety. It is vital to treat the child and the eating, sleeping or elimination symptom. Knowledge of the child's history, background and attitudes will enable those in charge better to deal with the child's needs and thus reassure him through their understanding and affectionate attitudes while giving whatever attention he needs.

Other manifestations of anxiety may be harder to diagnose because of the difficulty in differentiating between organic and emotional components in heart disease. These include tachycardia, arrhythmia, and other circulatory disturbances. The interaction of organic and emotional factors is intricate. Experience teaches us chronic anxiety and repressed hostile impulses may give rise to physical symptoms.

For example, we know that the arteriosclerotic heart is further damaged by the additional strain of anxiety placed upon it. This is also true in rheumatic or other forms of heart disease in children. It further underscores the necessity of treating the child rather than the heart. Not only should those who are actively taking care of the child try in every possible way to help him to be comfortable and happy even with his sickness but his whole program of activity and rest should be geared to therapeutic effectiveness.

3. Dunbar, F.: *Mind and Body, Psychosomatic Medicine*, New York, Random House, 1947. Also, *Your Child's Mind and Body, A Practical Guide for Parents*, New York, Random House, 1949.

WHEN hospitalization is required the child is deprived for long periods of time of one of his basic needs: home and family relationships. Adults with such awareness can do a great deal toward easing the adjustment of the child in the hospital. Visiting in the hospital has therapeutic value for the child. Many hospitals do not permit this because of the child's tendency to be "upset" when the parents leave or because of fear of interference with nursing routine. If the parents and the child are prepared adequately, visiting can be an experience that both parents and children will enjoy and from which they will receive reassurance. Parents may help the child more fully to accept the hospital experience. Their presence will make him feel less "separated" and thereby help him work toward the constructive goal of getting well enough to return to his home. The nurses, who can visualize themselves as mother substitutes, will, by dealing with the child in a kindly and comforting, supportive fashion, speed his recovery.

For brief periods of hospitalization there is distinct advantage in the parents' staying with the child constantly. A hospital experience with its formal atmosphere and white uniformed personnel can be frightening. It may cause delayed after-effects even though the child may show no immediate anxiety. The presence of parents helps prevent this. Those parents who have excessive anxiety about their child may need help in handling their own feelings so as to be better able to meet the needs of the child.

In periods of prolonged hospitalization, it may not be possible for the parents to visit the child regularly. In such cases, the child needs to have the facts explained to him carefully, and to know when he may expect to see his parents. Parents should keep up an intermediary contact through frequent letter writing and gifts. The nurses and other hospital

personnel have additional responsibility to serve as parent-substitutes for the child. Free interchange of ideas between parents and nurses facilitates effective cooperation.

SIMILAR principles operate during convalescence. This, too, may be an experience in "separation" or isolation. In some respects, the problem is more difficult simply because the child feels less sick and the parents have become more impatient. During convalescence from rheumatic fever, there is a peculiar need for constant supervision to prevent colds. But there is danger in such constant supervision, for it highlights invalidism and discourages independent growth towards maturity. So there is need for an exquisitely balanced median between too much care and too little.

The period following convalescence, when the child is returned to his home, is one which requires teamwork by teachers, church officials, recreational authorities, club leaders, social workers, nurses, parents and physicians. Adults with an understanding of the child and his illness, and his requirements for maintaining health with full regard for his limitations, can ease his return as a participating member of his group. Social workers, public health and school nurses can give invaluable aid to the other community leaders.

There is no greater example of the value of cooperative effort among doctors, parents, nurses, social workers, teachers, and community leaders than in the adequate treatment of the child with heart disease. Successful treatment of such a child, with full awareness of and consideration of his emotional needs, offers one of the greatest opportunities for the promotion of mental health and the regaining of physical health. It is a challenge worthy of earnest endeavor.

ROBERT CHOBOT, M.D.

New York, N. Y.

Pitfalls in the Management of the Allergic Patient*

Dr. Chobot offers a number of practical pointers here. Trial diets, he finds, are better than skin tests, and better than sudden conclusions based on single dietetic observations. In infantile eczema, the possibility of bacterial sensitivity should be entertained. In chronic asthma, too, the role of chronic infection is not to be forgotten. The values of — and limitations of—adrenocortical hormones are also reviewed.

PRACTICING physicians often differ as to the proper treatment of the allergic patient. A review of some of these variations would seem to be well worthwhile.

FOOD ALLERGY

Food allergy is one of the most controversial subjects in the field. Food testing is not an adequate means of diagnosing food sensitivities except where the ingestion of food produces symptoms within an hour. This has led to the extensive use of trial diets, the diagnostic values of which are superior to skin testing for foods. Unfortunately the physician is often too eager to accept unproved evidence. The ingestion of a food on one occasion is certainly inadequate proof of sensitization. If you accept the premise that the hypersensitive reaction depends upon the split products of digestion, it is evident that the time between ingestion and the production of the digestive chemical fraction must, within limits, be about the same whenever the food is eaten. This di-

gestive interval is quite long. At least three trial feedings will be required before any conclusion can be reached. In my observation such care is rarely observed. As a result, many foods are erroneously accused. Since the literature frequently mentions milk, eggs, cereals, fish and chocolate as causes, too many take the easiest course and simply remove these foods immediately from the patient's diet. This in itself would not be harmful if it were followed by a period of trial feeding to prove the assumption. This is almost never done. As a result the patient goes to several physicians. They add to the list of substances to the patient's detriment. Actually even in children, food allergy is not as frequent as the literature would indicate. It is even more infrequent in adults except in dermal allergies. There is, however, one large group of food allergies frequently overlooked: "Colics" and gastro-intestinal upsets of infancy. Pediatricians frequently ascribe the situation to family tensions or emotional influences. Actually the infant is suffering from a food hypersensitivity producing the symptoms of "colic" or even diarrhea. There is a growing conviction that many of the children diagnosed as having coeliac disease are really

*Presented May 19, 1954 at the 188th Annual Meeting of The Medical Society of New Jersey, Atlantic City, N. J.

cases of gastro-intestinal allergy. A history of "coeliac disease" is found in a fair number of children who subsequently develop asthma. I cannot help feeling that some of these could have been explained on an allergic basis.

Where one does obtain immediate and significant skin reactions, occasionally food sensitivity exists concurrently without positive reactions. In other words, in some cases we see both the immediate and delayed mechanisms operating at the same time, involving different foods. The diagnosis of food allergy is not the simple procedure that many believe.

There is only one way to treat food sensitivity; avoid the cause. In infants and children, however, sensitivity to milk and eggs poses difficulties. It is, in my experience, useless to attempt hyposensitization. In 98 per cent of the cases the allergy will undergo spontaneous involution. In the remainder it will plague the patient for many years and perhaps for the rest of his life. Nothing can be done really to affect a marked sensitivity to egg (for example) that persists into adolescence and adult life.

Is it possible to prevent sensitization by avoidance of substitute feeding? In my observation, the skin sensitizing antibodies are produced without contact. When they appear, the patient is potentially sensitive. The exact factor that precipitates clinical manifestations is unknown. We see the same situation in pollen sensitization. A patient may have skin sensitizing antibodies, give positive skin tests and yet not be clinically sensitive. For these reasons I cannot see how preventive diets can possibly be worthwhile.

To avoid misdiagnosing food allergy it is essential to prove the existence of the allergy to the complete satisfaction of both physician and patient. There is too great a tendency to ascribe vague gastric complaints to allergy.

INFANTILE ECZEMA

NO CASES still plague the pediatrician and the allergist to a greater degree than the eczemas of infancy and childhood. In part this is due to the early classifications and to those who asserted that skin testing was the solu-

tion. Even the most enthusiastic proponents of skin testing must admit that success is obtained in relatively few cases. Dermatologists classify allergic and contact eczema separately. Yet on biopsy, no skin pathologist will commit himself to a diagnosis without a history of the case and a description of the localizations of the lesions. Actually we must take a broader view and grant that the lesion *may* appear to be the same even though the allergen is the result of ingestion or contact. The sensitization of the deeper layers of the skin and the blood vessels may produce lesions which vary from an eczema to an urticaria. Many observers believe that inhalants can cause eczema. If they do, it is not common. I have failed to obtain therapeutic results with inhalant therapy. I have heard of eczemas being caused by pollens and inhalants. Where such diagnosis is made relief should follow proper hyposensitization.

When eczema appears in the early weeks of infancy, it generally starts with an eruption on the cheeks. The scalp may also be involved; this is the so-called "cradle cap." The rash on the face is usually a punctuate one and very pruritic. Small vesicles may appear, rupture, and gradually spread to other areas of the body until the entire skin becomes inflamed. After a time, as a result of scratching, serum exudes and a secondary pyogenic involvement occurs. The child may have a superimposed secondary infection which resembles a pustular eruption or even an impetigo. There may be a certain degree of oozing, but inflammation is the cardinal sign. Bleeding may occur when the crusts are removed. Thickening of the skin follows scratching. Scaling is usually a sign of seborrhea. Flexural eczema likewise appears in infancy, but the distribution is different. The rash starts on the cheeks and quickly spreads to the neck and other flexor surfaces. The scalp does not become involved. As the child grows, the eruption characteristically appears in the creases of the neck and the antecubital and popliteal areas. It may be generalized or it may be found only in localized patches. The skin is violently pruritic. The child, unless restrained, is likely to claw himself and remove the tops of the papules. This in turn may result in a secondary skin infection. With the

continuance of the lesions, the skin becomes thickened or lichenified. When diaper area is involved, the complication of an ammoniatic dermatitis from the urine results in severe inflammation. Regional nodes may be enlarged.

VALUE OF SKIN TESTS

SKIN tests have a limited value. I cannot say they are completely valueless. If you obtain a positive skin reaction to a food in an eczematous patient, it is essential to prove its significance. Occasionally on feeding, foods do produce itching and urticaria and even eczema. Far more frequently they have proved themselves to be a cause of asthma.

You cannot diagnose all eczemas by skin tests. It is this state of confusion that plagues the physician. What then is the solution as to procedure? I believe that a limited number of tests are indicated. Testing to a few important inhalants and foods will indicate the possibility of future trouble if they are positive. The important foods will, in a great many cases, give negative tests. Then we must have recourse to diets. Unfortunately these too are frequently negative. In infancy, foods play a role but only in certain cases which are readily diagnosed. Eczema can be caused by contacts but this is seldom considered in the younger child. There is no doubt that a reasonably large number have dermatitis as a result of sensitization to bacteria. This sensitization follows local skin infection caused by trauma, and more important, by focal infection in the nasopharynx. This sensitivity to bacteria almost always has an exacerbation whenever the patient has an acute upper respiratory infection. Removal of the infected focus results in a marked benefit particularly when it is followed by subsequent vaccine therapy. However, a large group still remains which does not fall in this category. For these, local therapy is still the only means of treatment. Adrenocortical hormones whether administered locally or parenterally have not proved worthwhile. Their discontinuance reproduces the lesions and, frequently, with a greater degree of violence than before. However, if sufficient effort is made to diagnose those with a definite bacterial etiology,

a reasonable number that at present are regarded as hopeless will be helped. It is unfortunate that this is rarely done. The removal of infected tissue produces improvement. Often injections of vaccines made from tissue cultures precipitate an acute exacerbation. This always occurs at the same dose and has the same interval of time lapsing between the injection and the occurrence of symptoms. However, when all these procedures have been completed there are a great many children who show no improvement. There is one point that should be emphasized: both the infantile and flexural eczemas are self limited. This often reassures parents that the child's skin will not be permanently marred. It should also be remembered by the practitioner when certain remedies seem to produce sudden and dramatic results. Local therapy must be used for this large group of children. Without attempting to go into local therapy in detail, I think that, in broad aspects, we can divide it into three divisions:

1. The acute inflammatory stage: this requires wet dressings until the acute inflammation subsides.
2. The oozing stage: where pastes are used to absorb the serum. Lassar paste without salicylic acid is an excellent preparation for this stage. Pastes have a drying effect and should be applied until the oozing stops. Oil is the best vehicle to remove the paste when it becomes very adherent.
3. The crusting stage with or without lichenification: tar in its various forms is usually effective. Mechanical restraints, particularly splints for infants, gloves for the hands and even masks for the face are of great value.

ASTHMA

THE usual division of asthma is into extrinsic and intrinsic forms. However, the meaning of the term "intrinsic asthma" varies widely. For the purposes of this paper, let us assume that intrinsic asthma and bacterial allergy are the same. The controversy concerning the acceptance of bacterial allergy is, I believe, coming to an end. There is a growing awareness of the importance of the role of chronic infection. This is, in turn reflecting itself in the therapy patients are receiving. However, we have practically no methods of determining which

organism is the cause of the bacterial hypersensitivity. The conclusion is usually the result of deductive reasoning after all other possible causes have been eliminated. Furthermore, ability to reproduce the asthma with fixed quantities of autogenous vaccine is our chief proof. This, one must admit, is not very scientific evidence. Yet in practical terms, we know that this type of patient benefits by the removal of chronically infected foci. In addition, it has been shown that patients with chronic suppurative disease have electrophoretic patterns with markedly lowered albumin levels and increased gamma globulin. This is found in the ineffective asthma of long duration and not in the extrinsic asthmatic without infection. After removal of infected foci, these patterns return to normal. This change in the albumin and globulin levels of the serum are important indications as to the effect of a chronic type infection.

The most common error is the unnecessary therapeutic use of house dust. While house dust is a frequent cause of asthma, it must be remembered that a slight skin reaction to dust extract hardly justifies the extensive use of the extracts. The use of combinations of inhalants for testing is fortunately not too common. Inhalants must be tested individually.

Probably the most frequent error is the failure to evaluate properly the possible infective factors. The importance of cultures cannot be over-emphasized. They indicate the type of infection. Secondly, they are available for the preparation of vaccines. The frequency of adenoidal recurrences emphasizes the relative lack of care often exhibited in doing an adenoidectomy. Palpating the nasopharynx in young children (as advocated by some) cannot be condemned too severely. It is inaccurate and painful. Lateral soft tissue x-ray radiation is a far more accurate technic. Large masses of chronically infected adenoids should be removed. This is important but it is still frequently overlooked. If infected adenoids remain with the expectation that they will shrink, there is a good chance that the child will develop chronic sinusitis. It is difficult to explain the reluctance one meets when the removal of such chronically infected tissue is advised. To-

day medical opinion is veering to the acceptance of bacterial allergy. Yet the main factor that must follow the removal of the infected focus is only grudgingly conceded. It is my experience that treatment with inhalants is of no avail if these foci are not eliminated. We meet more complicated pictures in the adult. First we have the problem of adequate diagnosis requiring good roentgenograms. Opaque contrast media may occasionally be required to outline adequately the contents of an antrum. Next, it is essential to have a surgeon familiar with sinus surgery, who can perform a competent operation. Without competent surgery, the task is hopeless. The proper selection of cases is the next problem. It is futile to take a patient with marked irreversible changes and expect a good clinical result. With a combination of proper diagnosis, good surgery and carefully selected cases the relief of these patients is not as impossible as may seem. In addition to competent surgery, careful vaccine therapy and avoidance of overdosage is essential. Obviously, any inhalant sensitivity should be treated concomitantly. The failures are largely caused by poorly selected cases and incomplete surgery.

Aminophyllin®, Demerol® and epinephrine are still in our armamentarium and should be used when indicated. The adrenal preparations are used only during the most difficult times. Their role should be one of a super-epinephrine longer duration.

EMOTIONAL INFLUENCES

THE role that psychic disturbances play in the allergic is like the role they play in other pediatric or medical condition. Their importance must be recognized. They are rarely the cause of the allergic syndrome by themselves. They must not be regarded as so important that other causes are ignored. This was dramatically brought to my attention in a case where a woman's asthma was ascribed entirely to emotional disorders. When I saw her, she had had long treatment with adrenocortical hormones. Nothing had been done about her foci of infection because her physician did not believe in

bacterial allergy. As a result, she was placed in a disturbed ward, told her asthma was psychic and that its treatment was to be psychotherapeutic. Her asthma became worse and she died. This fortunately is the only case of this sort that I have seen, but it is a pity that such extremes occur.

ADRENOCORTICAL HORMONES

BOTH cortisone and ACTH represent a great advance in the symptomatic treatment of allergic conditions. However, in pediatric allergy, they should be limited to the very severe episode, and should be used only for a short time. Attempts to use them for long periods in infantile eczema have proved to be futile. Side reactions are certain to occur. In addition they may interfere with growth and development. Thus, caution is indicated.

In the adult, dependence on these preparations for symptom relief without an attempt to

identify the etiology is a frequent error. These hormones have been widely used for a sufficient period of time to evaluate them properly. No one should expect these preparations to do more than give symptomatic relief. Even in chronic cases of asthma where a maintenance dose is all that can be given, such treatment cannot go on too long since side reactions frequently intervene. There are, in my experience, however, some patients who tolerate maintenance dosage well. But here you soon face a problem similar to addiction. Frequently great difficulty is experienced in trying to discontinue the hormone. One observation is certainly true. The smallest dose capable of controlling symptoms should be used. Unfortunately many of these preparations fail to work after a time. Then the patient is indeed in serious difficulty.

In short, good judgment and a conservative attitude must be adopted in the usage of these preparations. Where this is done, they have been helpful in the difficult allergic patient.

30 W. 59th Street

Atabrine in Lupus Erythematosus

Quinacrine hydrochloride (atabrine) has been found useful in the treatment of lupus erythematosus, especially the chronic discoid type.

Although the mechanism of quinacrine in lupus erythematosus is not known, it has been found that patients do respond well to this treatment. It has been suggested that the fluorescence produced by quinacrine interferes with the action of sunlight on lupus lesions. It has also been stated that yellowing of the skin by quinacrine is necessary to produce good results.

* Kierland, R. R., Brunsting, L. A. and O'Leary P. A.: Quinacrine Hydrochloride in the Treatment of Lupus Erythematosus. *Arch. Dermat. and Syph.*, December, 1953.

However Kierland,* *et al.* have obtained excellent results without perceptible yellowing. Fluorescence can be demonstrated long before the skin becomes yellow.

In patients obtaining good results from quinacrine improvement appeared within four to six weeks of therapy. If benefit is not apparent within the first month it is doubtful that this treatment will be effective.

In some patients signs of activity in the skin lesions disappeared on doses of 100 mg. of quinacrine daily; other patients required larger doses. When complete arrest or maximum improvement occurred, maintenance doses as low as 50 mg. daily were used. In some patients remissions lasted for six months after atabrine treatment was stopped.

Dislocation of the Carpal Navicular Bone Not Associated With Fracture

A case of dislocated navicular bone of the wrist unassociated with fracture is presented. The author comments on its rarity, methods of treatment and possible sequelae.

FRACTURE of the navicular bone is fairly common. *Dislocation* of the bone unassociated with fracture is rare. There have been scattered reports in the literature dating back to 1903 through 1949 of this type of injury. In some of these, there were fractures of the radial styloid associated with the dislocation or some other dislocations present. Only a few showed isolated dislocation.

The treatment consists only of replacement and a careful follow-up to determine whether aseptic necrosis will occur. If closed reduction fails, open reduction with immediate replacement would be the operation of choice. If an old dislocation is found and there are signs of necrosis, removal of the navicular is indicated.

CASE REPORT

A 26-year old carpenter fell off a 16-foot roof on June 4, 1951. He saw a truck just under the roof and put his hands out to break the fall. He does not remember exactly how his hands struck the truck. He also struck the front of his chest. He first noticed a pain about three inches *above* his right wrist on the radial side. He went to his family physician who fluoroscoped the chest and forearm but not the wrist because of the location of the pain. The wrist did not hurt him at that time. The next day, the entire arm and wrist began to ache. Three days later x-rays were taken.



Figure 1. Position of the dislocated navicular bone.



Figure 2. Position of the dislocated navicular bone.

The injury was shown as in figures 1 and 2. For two days, compression bandage was the only therapy. On June 11, 1951, a closed reduction was done. The bone was reduced easily by traction, manipulation and direct pressure over the dislocated bone. Traction was applied with the hand in forceful abduction. This was an attempt to widen the navicular space. Thereafter, the treatment was the same

as for a fracture; a gauntlet type plaster cast was applied which included the thumb in abduction. Plaster was removed on August 6. Further x-rays showed that the bone had remained in place. There was no evidence of aseptic necrosis. Follow-up x-rays two years later did not show any fracture. The patient has regained full use of the wrist without pain.

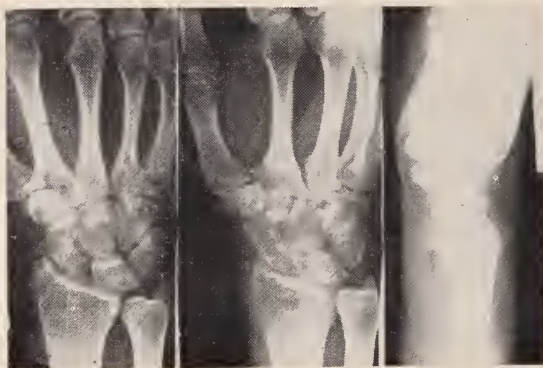


Figure 3. Navicular in normal position (August 6, 1951).



Figure 4. Navicular in normal position; with no evidence of necrosis (April 28, 1952).

94 South Main Street

Research Spending Down

Although total federal spending for scientific research shows a 10 per cent decrease this year under last, approximately 2 per cent more will be spent in medical research. This is the estimate of the National Science Foundation. Federal agencies will spend about \$2 billion for all forms of scientific research during the present fiscal year, in contrast with last year's \$2.23 billion. Biggest drop came in funds allocated for applied research in physical sciences, where the figure dropped from \$1.5 billion to \$1.4 billion. Research related to national security accounted for a high percentage

of the total—85 per cent this year. The breakdown shows that 87 cents of each research dollar is obligated for the physical sciences, 11 cents for the life sciences and 2 cents for the social sciences. Of U.S. agencies, seven accounted for 98 per cent of the total to be spent on scientific research—Defense Department (75 per cent of the total), Atomic Energy Commission, National Advisory Committee for Aeronautics, and the Departments of Agriculture, Interior, and Health, Education and Welfare.

Trustees' Meeting

Abstract of the September 26 (1954) Session.

On September 26, 1954, the Board of Trustees met in Trenton and:

—Approved of *ad interim* appointments made by the President to the Blood Bank Commission, the Planning Committee of the New Jersey League of Nursing, to the newly established Section on Ophthalmology, to various liaison committees, and to fill vacancies in sections on urology, clinical pathology, and otolaryngology.

—Created a committee to study the rehabilitation needs of the people of New Jersey and to develop a program to meet those needs.

—Confirmed the selection of Henry Davidson as editor of the JOURNAL.

—Empowered a "cabinet" (consisting of the Board Chairman, the past-president, and the current president, president-elect and vice-presidents) to speak in emergencies in the name of the Society.

—Approved various activities directed towards encouraging citizens' approval of the medical school referendum.

—Approved various Woman's Auxiliary projects for 1954-55.

—Set up in a reserve account the "Membership Directory Fund" to be ear-marked for printing of the 1955 Directory.

—Authorized the Treasurer to make certain types of investments from funds now in non-interest bearing accounts.

—Approved the professional audit of the Society's funds as drafted by Teunon and Company.

—Approved the revised fee schedule of the Veterans Administration.

—Referred to the Subcommittee on Medical Practice the suggestion that steps be taken to give New Jersey the kind of "privileged communication law" which 32 other states have to protect physician-patient confidences.

—Received Dr. Costello's report of the actions at the recent meeting of the A.M.A.'s House of Delegates.

—Authorized a dinner for A.M.A. delegates from all states attending the A.M.A. convention in Atlantic City in May 1955.

—Received with gratification a report that the Annual Meeting in 1954 set a new high in its attendance record.

—Approved provisional plans for our 1955 Annual Meeting.

—Asked the county societies to make a survey of malpractice experience in their areas.

—Approved a plan which would instruct Blue Cross to deal with county medical societies, and apply enrollment ratios in excess of 51 per cent in one county to those counties which had a smaller enrollment.

—Authorized a plan for developing a roster of consultants to Medical-Surgical Plan. The county societies would prepare the original list, following established criteria. A copy of each list would be filed at the office of The Medical Society of New Jersey. The lists would be revised annually.

—Referred to the Subcommittee on Medical Practice a plan calling for a study of the ways in which county societies could collect evidence of the corporate practice of medicine by local groups.

Henry C. Barkhorn Memorial Center

Named for one of our state's most distinguished and dedicated otologists, the Henry C. Barkhorn Memorial Hearing and Speech Center of the Newark Eye and Ear Infirmary initiated services for the community on January 16, 1953. The demand necessitated re-

novation of a separate building on hospital grounds which now houses the Center.

Basic aims of the Center are to aid individuals afflicted with hearing losses by determining the extent of loss and in prescribing the hearing aid, if medically indicated, which gives

the individual maximum benefit. Prerequisite for all hearing tests at the Center is a complete examination by an otolaryngologist.

The second aspect of the Center is its speech therapy program. In this rehabilitation program, children and adults are enrolled in group and individual sessions depending on similarity of defect and age. Speech therapy patients are accepted by medical referral.

Supervision of the Hearing and Speech Center is by an otorhinolaryngological board with consultants in: otorhinolaryngology; neurology; psychiatry; ophthalmology; dentistry; pediatrics; geriatrics and internal medicine.

Services rendered fall into six categories: (1) Audiologic evaluation; (2) Hearing-aid evaluation; (3) Psychogalvanic skin response tests; (4) Differential diagnosis of obscure conditions; (5) Prosthetic service with respect to ear pieces, including impressions and molds; (6) Speech evaluation and rehabilitation services.

The audiologic evaluation includes various types of audiograms, and analysis of speech reception thresholds, as well as studies of speech discrimination. Facilities are available for the

detection of malingerers. The "differential diagnosis" service includes localization of the auditory loss with neurologic and psychiatric examinations.

Speech evaluation and rehabilitation facilities may be summarized under the following headings:

- (a) Deaf—language acquisition, speech therapy and auditory training.
- (b) Hard of hearing — speech therapy, speech conservation and auditory training.
- (c) Auditory training—group and individual sessions according to needs of patients.
- (d) Lip reading—group and individual sessions according to needs of patients.
- (e) Cerebral palsy—rehabilitation of speech.
- (f) Cleft palate—speech therapy.
- (g) Aphasia—language rehabilitation.
- (h) Stuttering—speech therapy.
- (i) Delayed speech—habilitation of speech.
- (j) Articulation—speech therapy.
- (k) Aphonias—dysphonias—speech therapy.

Herbert E. Rickenberg is Director of the Center. Individuals of all ages are accepted. Reports are made to referring physicians as to diagnosis and recommendations. Suitable cases are accepted for rehabilitation. Both group and individual sessions are available.

Approved Residencies in New Jersey

As of January 1954, the following residencies in New Jersey hospitals were approved by the American Medical Association. This tabulation is adapted from page 423 of the September 25 (1954) Journal of the American Medical Association.

- A: Anesthesia
- CD: Contagious Diseases
- Ch: Chest Diseases
- Gy: Gynecology and Obstetrics
- GP: General practice residency
- I: Internal Medicine
- Op: Ophthalmology
- Or: Orthopedics
- Pa: Pathology
- Pe: Pediatrics
- Ps: Psychiatry
- S: Surgery
- T: Thoracic Surgery
- X: X-ray

Atlantic City Hosp. I, Pa, X, S, U
 Bayonne Hospital: U
 Belleville, Essex County Hosp.: CD
 Camden Municipal Hosp.: CD

Camden, Cooper Hosp.: I, Gy, Pa, Pe, X, S, U
 Camden, West Jersey: Pa, S
 Cedar Grove, Essex County (Overbrook): Ps
 Englewood Hospital: I
 Flemington, Hunterdon Medical Center: GP
 Glen Gardner, State San: Ch
 Greystone Park, State Hosp.: Ps
 Hackensack Hospital: I, Gy, X, S
 Jersey City, Pollak Hosp.: Ch, T
 Jersey City, Medical Center: A, I, Gy, Op, Pa, Pe, S, U, X
 Jersey City, Margaret Hague: Obstetrics
 Long Branch, Monmouth Memorial: I, Or, Pa, S, Obstetrics
 Lyons, VA Hospital: Ps
 Marlboro, State Hospital: Ps
 Montclair, Mountainside: GP, I, Pa
 Morristown Memorial Hospital: Pa
 Mt. Holly, Burlington County Hospital: I, Pa, X, S
 Neptune, Fitkin: I, S
 Newark, Babies (Coit Memorial): Pe
 Newark, Crippled Children: Or
 Newark, St. Barnabas: Pa, S, X, Plastic Surgery
 Newark, Beth Israel: I, Gy, Pa, S, X, Obstetrics
 Newark, Martland Medical Center: I, Pa, S, U, X, Otolaryngology

Newark, Eye and Ear Infirmary: Op
 Newark, Presbyterian Hospital: Pa, S
 Newark, St. Michael's: I, Pe, Pa, Obstetrics
 New Brunswick, St. Peter's Hospital: I
 Orange, N. J. Orthopedic: Or
 Orange Memorial Hospital: I, Or, Pa, S, U, X
 Paramus, Bergen Pines: Ps, Ch
 Passaic General Hospital: Pa
 Passaic, St. Mary's Hospital: Pa
 Paterson General Hospital: I, Pa, Obstetrics

Paterson, St. Joseph Hospital: A, Pa
 Plainfield, Muhlenberg: Pa
 Summit, Overlook Hospital: GP
 Teaneck, Holy Name Hospital: Obstetrics and
 Gynecology
 Trenton, Mercer Hospital: Ps
 Trenton, State Hospital: Ps
 Trenton, Orthopedic Hospital: Or
 Trenton, St. Francis: I, S
 Verona, Essex Mountain Sanatorium: Ch

Obituaries • • •

DR. JOHN J. RITTER

Dr. John Ritter, emeritus member of The Medical Society of New Jersey and of its Passaic County component died on October 27. He was born in Paterson in 1871 when Ulysses S. Grant was President. He was graduated in 1901 from the Baltimore Medical College and practiced in Paterson for almost a half century.

Dr. Ritter was active in civic, medical society and church affairs. He was one of the founders of Paterson's Catholic Youth Organization. He was physician to numerous institutions. Dr. Ritter remained in active practice until the age of 73, and then retired to Adams, Massachusetts where he was living at the time of his death.

DR. R. ELMER SCHALL

On October 14, Dr. R. Elmer Schall, one of South Jersey's medical leaders died at the age of 78. After being graduated from the College of Physicians and Surgeons in Baltimore in 1904, he came to Camden where he practiced continuously from 1918 to 1954. He was a founder of the old Bellevue Hospital of Camden. He was chairman of the medical examiners of one of the South Jersey draft boards, and was vice-president of the Bishop Bayley Building and Loan Association. For three decades, Dr. Schall was actively associated with the pioneer tuberculosis clinic sponsored in Camden by the County Tuberculosis Association.

DR. HOWARD SCHWARZFELD

One of the state's most promising careers in dermatology was prematurely terminated with the untimely death of Dr. Howard K. Schwarzfeld at the age of 39. Dr. Schwarzfeld died on October 17. He was a Kearny practitioner, a diplomate of the American Board of Dermatology and active in church and medical society affairs. Dr. Schwarzfeld was an alumnus of the medical school of Louisiana State University, from which he had received his M.D. in 1939. He entered the Navy in 1941, eventually rising to the rank of full commander. He was chief medical officer at Floyd Bennett Field towards the end of World War II.

DR. GEORGE H. SEXSMITH

Word has recently reached the Society of the death, on September 20, of Dr. George H. Sexsmith, originally of Bayonne, who since his retirement from practice had lived in Los Angeles, California.

Dr. Sexsmith was born before Abraham Lincoln was elected President. He was born in upper New York State on June 30, 1859, and graduated in medicine from the College of Physicians and Surgeons, Columbia University, in 1890. He became an active member of Hudson County Medical Society in 1908. Honorary membership in the County Society was conferred upon him in 1939. He was an Emeritus member of the Hudson County Medical Society and The Medical Society of New Jersey.

In point of age, 95 years, Dr. Sexsmith was considered the dean of Hudson County Medical Society and was probably the senior physician of The Medical Society of New Jersey.

Diabetes, a Public Health Problem

About a million persons in the United States have diabetes mellitus but are not under medical management because they are not aware that they have it. In New Jersey, the figure will approximate 50,000. When we add to this, the somewhat larger total of "potential diabetics," it becomes clear that we have in diabetes a problem of sufficient magnitude to require serious case-finding efforts as well as educational and preventive efforts.

The importance of diabetes as a health problem logically suggested that it be included as an area of effort in our Division of Chronic Illness Control, which was set up in response to legislative directive. The prevention of conditions which lead to ill health is a traditional public health function. It is therefore no departure from basic responsibility for public health agencies to help in discovering early, symptomless diabetics and to help bring them under prompt medical care so as to help avoid acute illness or its potential complications.

We in public health have a circumscribed function. We do not treat. We practice preventive medicine. With respect to diabetes, we make our most effective contribution in case-finding efforts which will result in the diabetic receiving earlier treatment from the physician of his choice. Case-finding can be both expensive and relatively ineffective unless it is applied to fairly large numbers of persons. That requires organization and time. The busy physician is glad to participate to the extent that his time will permit. But if we can relieve him of some of the tedious problems of organization and distribution of supplies, we leave him relatively freer to use his particular skills more effectively in the medical management of those who are brought to him as a result of screening efforts.

This year, for example, 100,000 "Drey-paks" will be made available for distribution to people in New Jersey. The parent-teacher associations have agreed to undertake the distribution of these in most communities. The effort includes the participation of many local health officers, the District State Health offices, many hospital laboratories, physicians

and the chairman of the Diabetes Detection Committee of each county medical society. It becomes clear that the coordination, distribution, and publicity require a good deal of planning and effort if the case-finding project is to be a success.

In the past, the weak point in the program has been the failure to secure a clear picture of what was accomplished. That weakness can be remedied. It is important that the "Drey-paks" be used and that we know ultimately with what result. The unknown diabetics should be found and brought under treatment. Case-finding methods need to be evaluated and, whenever possible, made more effective and efficient. If the private practitioner makes a positive diagnosis of diabetes and the patient is under his management, we* should like to know it so that we may judge the effectiveness of our case-finding methods. It may seem unimportant in the individual case, but if there are hundreds of such cases throughout the state and we do not know about them, we cannot effectively appraise our case-finding efforts.

Our approach is to strengthen the community's ability to deal with this problem at the *community* level. The State Department of Health has, for example, provided case-finding equipment at two hospitals to strengthen the hospital's resources for a continuing case-finding program among patients referred to it. Similarly, we have provided funds for trained personnel on a grant-in-aid basis for such purposes.

The public health agency can make another contribution through its public health nurses. All physicians know that a diabetic may become overconfident and that this may lead to carelessness. He may fail to keep his appointments. He may pay little heed to his diet, and enjoy a false sense of well-being, sometimes to the point of disability. It may take a collapse to make him realize that he cannot be careless. The public health nurse can assist the physician in handling these persons. Through the visit to the home, she can stress the importance of consistent medical management. Often, she can motivate the patient to return to his physician and to re-establish his

*State Department of Health

adherence to self-discipline, diet, insulin, exercise, and periodic checkups. This illustrates once again the beneficial results which can accrue when there is an effective working relationship between the physician and the public health nurses of his community.

Diabetes is easy to discover, assuming the effective participation of the people. Means for detection are simple and effective as contrasted with some other diseases. Once diagnosed, the treatment requires no isolation and only advanced complications call for surgery. It is not contagious. The treatment is suscep-

tible to relatively easy management once the cooperation of the patient has been enlisted.

With all these factors in our favor, together we can do a good job. There is something for each to do in this over-all effort. If each of us does what is rightly expected of him, together we will ferret out, diagnose and treat an increasing number of the diabetics in our communities with great benefit to them individually and, in aggregate, to the community as a whole.

DANIEL BERGSMA, M.D.
State Commissioner of Health

The Latitude of Alcoholism

Drinking habits vary to such an extent from one country to another that they give rise to different problems of alcoholism. Thus this was one of the major questions discussed by the joint meeting of the World Health Organization's Committee on Alcohol, which just finished a session at Geneva. Experts from six countries attended the meeting.

The most striking difference, the Committee was told, exists between countries where distilled spirits are rapidly consumed, frequently leading to amnesias, and those countries where wine or beer drinking is predominant. The blackout phenomenon, which consists of loss of memory, is common in Anglo-Saxon and Nordic countries, but is almost unknown in the wine and beer drinking countries. The blackout phenomenon is so rare in wine producing France that the French have no word for it.

In these wine-drinking, and some of the beer-drinking countries, drinkers will take in wine and beer day in day out from early rising till retiring to sleep. Comparatively little overt drunkenness is seen, but the resultant alcoholism can lead to cirrhosis of the liver.

In continuous heavy wine or beer drinking a physical dependence on alcohol may arise. Drinkers reach "an inability to stop drinking." Such drinkers cannot go without their large, daily intake.

With heavy spirit drinkers, on the other hand, an entirely different pattern is observed. Typically, after an initial phase during which spirits may be drunk daily in comparatively constant quantities, this habit may change to "drinking bouts" leading to severe intoxication. Such a drinker may subsequently find himself compelled to continue drinking, in the bout, and will ingest alcohol in increasing quantities until he is stopped by loss of consciousness, or other internal or external factors. After the bout, there is often a short or even long period of abstinence, but "loss of control" is evident once a drinking bout has started.

The heavy drinker, even if his excess is occasional, constitutes a grave problem because the resultant acute intoxication can lead to industrial or traffic accidents, criminal behaviour increased exposure to venereal disease, and other undesirable consequences.

Poultry Industry Charged with Being Unsanitary

Certain parts of the poultry industry are charged with being unsanitary. This is detailed in a pamphlet entitled "Congress Should Probe Sick and Diseased Poultry." The brochure is written by Hilton Hanna and released

by the Amalgamated Meat Cutters of America. Interested readers may obtain copies by writing to that union at 2800 Sheridan Road, Chicago 14, Illinois.

Announcements • • •

Diabetes Award

The New Jersey Diabetes Association is offering the J. Fred Johnson Award of \$150 for the best essay submitted on problems relating to diabetes mellitus. Essays may cover either clinical or research investigations. They may include original studies or unusual case reports with suitable and complete comments.

The presentation should not exceed 3000 words. Submitted in double spaced typewritten copy, in duplicate, it must reach the Award Committee at 91 Lincoln Park, Newark, not later than June 1, 1955.

Candidates are restricted to residents or interns in New Jersey hospitals, or to New Jersey physicians in practice no longer than five years.

A place will be reserved on the program of the Metabolic section of The Medical Society New Jersey at its annual meeting for the presentation of the winning essay by the author. It will be published in an appropriate journal.

This Award was made possible through the generosity and altruism of the late J. Fred Johnson who wished to stimulate the interest of young physicians in this disease.

Public Health Service Commissions Now Available

The Public Health Service will hold examinations for commissions in its corps next February. Applications must be received by January 12, 1955. The form is obtained from Division of Personnel, U. S. Public Health Service, Washington 25, D. C. Clinical and research opportunities in all phases of medicine are available. Service in U.S.P.H.S. fulfills the military draft obligation of the young physician. Salaries at entrance range from \$6000 to \$6920. Retirement privileges (three-fourths of base pay) are included.

\$1000 Award for Geriatric Paper

Awards averaging 300 British pounds each are announced for papers reflecting "well conceived research relevant to the basic problems of aging." Deadline date is February 28, 1955. Papers should be sent to, and further details may be obtained from Director, Ciba Foundation, 41 Portland Place, London (England) w-1.

American Board of Physical Medicine and Rehabilitation

Next examinations for the American Board of Physical Medicine and Rehabilitation will be held in Philadelphia, June 5 and 6, 1955. Final date for filing applications is March 1, 1955. Applications should be mailed to Dr. Earl C. Elkins, 30 N. Michigan Ave., Chicago 2, Illinois.

Making Nursing Care More Effective

Any hospital administrator, nurse or medical staff official, can, at the small cost of 25 cents, get the new USPHS brochure *How to Study Nursing Activities*. Send the quarter to the Superintendent of Documents, Government Printing Office, Washington 25, D.C. The book is a treatise on how to use nursing services more efficiently. In the words of Edwin Crosby, this brochure is "a new tool in finding specific answers to questions on how to conserve the time of professional nurses." It is adaptable for any hospital large or small. It is, perhaps, the only short book in the world, which shows you how to determine the extent to which nursing time is distributed between duties requiring nursing skills and those which don't.

Titles of Medical Articles

Each month in this space, the Publication Committee or the Editor will present a problem in medical writing. Here, too, we will answer questions about the JOURNAL in particular or medical writing in general.

If a medical article has a catchy title, I'll read it. At least, I'll start in to read it. After that it's up to the author to keep me awake. But if the title doesn't hook my interest, I'll put the journal aside with the intention of reading that paper when I get some free time. And I never get any free time.

All of which means that medical authors ought to pay more attention to article titles. The way I look at it—and I think most doctors are the same—the “Table of Contents” is a sort of show case. I look it over and pick out the item that interests me. The only part of the article that appears in that show case is the title.

A title ought to be short. If it runs to more than eight or ten words, I'll pass it up. So will most of us. If a short title is too general, let the author use a subtitle. Here's what I mean. A pediatrician I know made a clinical and bacteriologic analysis of 46 cases of diarrhea in children. He called it in his first draft:

CLINICAL AND BACTERIOLOGIC STUDY OF DIARRHEA IN 46 CHILDREN

The editor set it up in two lines. The title was simply DIARRHEA IN CHILDREN. The subtitle was “Clinical and Bacteriologic Study of 46 Cases.” In this way the title was kept short, but the specific nature of the study was indicated by the subtitle. Any pediatrician, family doctor or gastro-enterologist would be attracted by the title—which was snappy, compact and promised to reveal something about a common condition. And the subtitle indicated the exact focus.

I once saw a manuscript (mercifully never published in that form) with this whopping title:

COMPARATIVE ANALYSIS OF RESULTS IN OPERATIVE AND NONOPERATIVE METH- ODS OF TREATMENT OF LOW BACK PAIN

It would seem to me that the simple title TREATMENT OF LOW BACK PAIN would have been enough—and would have hooked reader

interest. The subtitle could have been “Results in Operative and Nonoperative Cases.”

Why does any author use a title like this?:

CLINICAL EXPERIENCE IN THE TREAT- MENT OF LOW BACK PAIN BY THE USE OF TRACTION APPLIED TO THE LOWER EX- TREMITIES

Surely some one should tell him that “Clinical Experience” is an unnecessary prefix. No one would think he was reporting animal experiments or laboratory studies *in vitro*. Why did he need “use of?” What's the difference between “Treatment by Traction” and “Treatment by the Use of Traction?” And would any one assume that you treated low back pain by applying traction to the arm? So the reference to the lower extremities seems unnecessary. This clumsy 19 word title could have been compressed to 7 words: “Treatment of Low Back Pain by Traction.”

A FELLOW-EDITOR showed me this title: “Toxic Dermatologic Reactions to Overdose of, or to Prolonged Use of Penicillin.” He dehydrated it to “Skin Reactions to Penicillin.”

Any one smart enough to write an acceptable medical paper is smart enough to write a compact title. Only he may not be willing to take the time needed to squeeze a'l the water out of the title. It takes more time to work out a short title than a long one.

Another article I leave unread is the one with a too-general title. The author who called his article “A New Diagnostic Sign in Appendicitis” may have expected to achieve immortality. He didn't. The title gave no clue as to the subject: it was much too general. Actually the new sign was left sided hyperalgesia. *That* should have been worked into the title. He could have called it: Left sided Hyperalgesia in Appendicitis. Almost any surgeon would read a paper with *that* title.

Maybe you would be enchanted by a title like “An Interesting Obstetrical Problem” or “Complications of Convalescence.” But most of us would turn swiftly to the next article.

Industrial engineers say that packaging is the secret of successful retail merchandising. If an author really wants the reader to take it home, he ought to wrap it up in a smooth and compact package.

HENRY A. DAVIDSON, M.D. *Editor.*
THE JOURNAL.

County Society Reports • • •

Burlington

A regular monthly meeting of the *Burlington County Medical Society* was held September 9, 1954 at the Riverton Country Club.

The guest speaker, Dr. James Eckenhoff (Associate Professor of Anesthesiology at the Graduate School of Medicine) discussed the treatment of barbiturate poisoning and the use of Nalline as a narcotic antagonist.

Dr. Joseph Ziegler of Burlington was accepted for membership by transfer from the Philadelphia County Medical Society.

J. ARTHUR STEITZ, M.D.
Reporter

Cumberland

The October meeting of the *Cumberland County Medical Society* was called to order by its president, Dr. Frank J. T. Aitken. The meeting was held on October 12, 1954 at the Cumberland Hotel in Bridgeton.

During a short business meeting, the Executive Committee presented the name of Dr. Margaret A. Warlow for Honorary Membership in the Cumberland County Medical Society.

Speaker for the day was Dr. Irving J. Wolman, Hematologist at the Children's Hospital in Philadelphia and Associate Professor of Pediatrics at the University of Pennsylvania. Dr. Wolman's subject was "Recent Advances in the Blood Diseases of Children," which was both interesting and informative.

The Society was delighted to have also as guests, the Gloucester County Medical Society with a large number of their members present.

Following the short business meeting and the scientific session an excellent dinner was enjoyed.

GEORGE F. RISI, M.D.
Reporter

Gloucester

With Dr. John J. Laurusonis in the chair, the regular meeting of the *Gloucester County Medical Society* was held at the Woodbury Country Club, September 16, 1954.

The speaker for the scientific program was Dr. Anthony Sindoni, Jr., Chief of Metabolism, Philadelphia General Hospital. Dr. Sindoni presented a comprehensive and practical talk on diabetes. Discussion was opened by Dr. James G. Kehler, after which many questions were answered by the speaker.

During the business meeting the following were elected to full membership in the county society: Thomas F. Flynn, M.D. of Woodbury, and Samuel I. Nichols, M.D. of Pitman.

A committee was appointed to confer with the Woman's Auxiliary concerning the feasibility of meeting the same night and place as the county society.

It was suggested that school physicians try to standardize quarantine regulations for all the county schools.

A committee was appointed to study the by-laws and bring in any recommendations for revision.

Dr. Chester I. Ulmer discussed the forthcoming social session.

The Woodbury Country Club was the scene of the gala Annual Social Session of the Gloucester County Medical Society on October 21, 1954. Our president, John J. Laurusonis, M.D., was an excellent toastmaster, and abetted by Chester I. Ulmer, M.D., Chairman of the Program Committee, put on a memorable affair.

Elton W. Lance, M.D., President of the State Medical Society, gave a few well chosen remarks, mostly concerning the referendum for the State Medical-Dental School. The eloquent executive officer of the State Society, Richard Nevin, rendered a few pearls of wisdom.

Probably the largest gathering ever of Gloucester County physicians, their wives and guests then listened to the internationally famous columnist and correspondent of the Philadelphia *Inquirer*, Ivan H. Peterman. In his usual frank manner, Mr. Peterman discussed "The Free World vs. Communism," drawing upon his worldwide experience in foreign and domestic affairs. Those who missed this dynamic dissertation should be sorry and ashamed.

The favors, door prizes, music and food, as well as the fellowship made this an occasion to remember.

LOUIS K. COLLINS, M.D.
Reporter

Hudson

Hudson County Medical Society initiated its 1954-55 season on October 5 when the first meeting took place at Jersey City Medical Center. Dr. Edward G. Waters of Jersey City presided.

The Secretary read a communication from the North Hudson Physicians' Society defending a member of the Society with respect to his management of a case which recently received unfavorable newspaper publicity. The final paragraph of the communication read:

"The executive committee recommends, due to

the growing adverse publicity in newspapers and magazines, that some action be taken to combat this unfavorable and unjust criticism of the medical profession. We further recommend that this action be taken on local, state, and national levels."

Dr. Joseph L. Ecker of Jersey City was elected to active membership.

Dr. Waters read a telegram and letter from Dr. Elton W. Lance, president of The Medical Society of New Jersey, on the subject of the State Medical-Dental School and Health Center. A majority of those present voted in favor of an affirmative vote on the November referendum.

Guest speaker was Dr. William O. Wuester, Attending Surgeon at Elizabeth General Hospital and Director of the James S. Green Memorial Cancer Clinic. Dr. Wuester delivered an illustrated lecture on "Cancer of the Skin—Radiologic and Surgical Aspects."

STEPHEN A. MICKEWICH, M.D.

Reporter

Mercer

The *Mercer County Component Medical Society*, at its annual meeting on November 10, elected the following officers for the year 1955-1956: *President* — Dr. Albert F. Moriconi; *Vice-President* — Dr. Jacob M. Schildkraut; *Secretary-Reporter* — Dr. Samuel J. Lloyd; and *Treasurer*—Dr. Warren E. Crane.

HENRY L. DREZNER, M.D.

Reporter

Middlesex

The regular monthly meeting of the *Middlesex County Medical Society* was held at Roosevelt Hospital, Metuchen, on October 20, with Malcolm M. Dunham, M.D., the president, presiding. Minutes of the June and September meetings were approved as read.

On recommendation of the Medical Judicial Ethics Committee, Dr. Haywood, Chairman, Dr. Vincent J. Cannamela of Perth Amboy was elected to a two year period of Associate membership.

Announcement was made that the Cerebral Palsy Clinic will be conducted at the Perth Amboy General Hospital by Dr. Winthrop Phelps.

Dr. Calvin reported that 273 cards were sent out to members of the Society concerning the 1954 Christmas Party; of them, 53 replied that they would attend; 65 that they would not attend and 157 members did not answer. The Christmas Party plan has, therefore, been abandoned. A business meeting will be held instead in December.

The speaker of the evening, Dr. Max P. Cowett, Assistant Clinical Professor of Surgery at New York University Medical School was introduced by Dr. Henry T. Weiner. Dr. Cowett's subject was "Newer Concepts in Office Proctology."

The following resolution was adopted:

Whereas, the health and well-being of the children and adults of New Jersey require a continuing adequate supply of trained professional health personnel to minister to the needs of the people; and

Whereas, the state lacks a center for the training of health personnel, as well as for proper research, development of materials and techniques and for the dissemination of scientific discoveries and advancements to men employed in the various public fields in New Jersey; and

Whereas, New Jersey is among the more prosperous and populous states of the Union and well able to afford such training and a health center;

Now, Therefore, Be It Resolved; That the Middlesex County Medical Society urges all citizens to join with its members in voting "Yes" on the referendum to establish a State Medical-Dental School and Health Center in New Jersey.

The following memorial was then spread upon the minutes:

Once again this Society has suffered the loss of one of its members, a man who was guided in his career by the highest ideals of his profession; quiet and retiring association with his colleagues. His qualifications were recognized by his election to the office of vice-president with the ultimate goal of being made the head of this Society.

Therefore, be it resolved that the Middlesex County Medical Society go on record to state that the death of Doctor Lavern Clark Bassett be entered on the Minutes of this Society and the proper Officers be instructed to prepare a suitably engrossed resolution to present to the family of Doctor Bassett conveying the sympathy and condolences of this Society.

A request by Doctor Calvin, Program Chairman, to change the County Society meeting in April to the second Wednesday was passed.

A motion by Dr. Dolin for the Society to go on record as approving Assembly Bill A-56 (as already approved by The Medical Society of New Jersey) was passed.

IVAN B. SMITH, M.D.

Reporter

Monmouth

Fort Monmouth was host to the *Monmouth County Medical Society* at its regular monthly meeting held at the U. S. Army Hospital there on October 27. A tour of the hospital and a delicious steak dinner preceded the meeting.

Col. Otto L. Churney, Post Surgeon, opened the meeting by introducing Maj. Gen. Victor A. Conrad, Commanding General of Fort Monmouth and Brig. Gen. Crawford F. Sams, Surgeon of First Army. General Conrad extended a welcome to the Society on behalf of the Army. General Sams commented favorably on the excellent liaison that existed between the Army medical personnel and the civilian physicians of Monmouth County. Dr. Howard Pieper, president, expressed the great appreciation of the Society.

The scientific program consisted of an address by Lt. Col. Carl F. Tessmer, M.C., Chief, Radiation Injury Pathology Section, Armed Forces Institute of Pathology. His subject was "Long Term Studies in the Survivors of the Atomic Bomb."

During the business meeting the Society unanimously endorsed the bond issue for the establishment of a Medical-Dental School in New Jersey.

The following were elected to active membership: Drs. James F. Clark and Carmen J. Scarpellino, Red Bank; and Edward I. Panzer, Marlboro State Hospital.

DONALD W. BOWNE, M.D.
Reporter

Morris

The regular meeting of the *Morris County Medical Society* was held at the Warner-Chilcott Auditorium on October 21.

Speaker of the evening was Dr. Bret Ratner, Director of Pediatric Allergy at the New York Medical School. Dr. Ratner spoke interestingly on allergy in children. He discussed psychosomatic aspects of allergy in children. A busy question and answer period followed the address.

The referendum for a Medical School will be on the ballot on November second and there was discussion and planning for activity. Newspaper releases have been prepared and a sum was appropriated for purchase of radio time to be used in explaining the referendum.

ALBERT ABRAHAM, M.D.
Reporter

Warren

The October meeting of the *Warren County Medical Society* was held on October 19, at the Hollow Golf Club, Phillipsburg. Dr. A. U. Bertland presiding.

The first portion of the meeting was devoted to the scientific program, the speaker being Dr. W. L. Jamison, cardiac surgeon, Hahnemann Hospital

Philadelphia. Dr. Jamison gave a very interesting discussion about cardiac surgery.

Following the scientific program, the business meeting was held. Dr. Stanton Syckes of Belvidere was elected to active membership.

The Medical-Dental School referendum was discussed and the members voted unanimously to do as much as possible to bring this issue to the Warren County peoples' attention and point out the advantages of having a medical-dental school in New Jersey and persuade them to vote favorably for the referendum. A detailed publicity campaign for this referendum was voted to be carried out in Warren County.

An enjoyable social get-together followed the business meeting.

VOLMAR A. MERESCHAK, M.D.
Reporter

New Jersey Ophthalmological Society

Dr. Hubert N. Alyea, chemistry professor at Princeton University, captured the imagination of his audience as he addressed the members of the *New Jersey Ophthalmological Society* and their guests November 11 at the Princeton Inn. Dr. Alyea spoke on "Atomic Energy—Weapon for Peace."

Dr. C. Byron Blaisdell, Chairman of the Board of Trustees of The Medical Society of New Jersey, was a guest of honor at the dinner which preceded the program.

During the business meeting in the afternoon the physicians elected H. L. Harley, M.D. of Atlantic City and E. S. Sherman, M.D. of Newark, honorary members of their society. The following were elected to office for the year 1955: Dr. George P. Meyer, Camden, *president*; Dr. Lee W. Hughes, Newark, *vice-president*; Dr. Charles E. Jaeckle, East Orange, *secretary*; and Dr. Jay E. Mishler, Atlantic City, *treasurer*. Drs. Louis A. Amdur of Jersey City and Edward A. Atwood of Paterson were elected directors. Dr. A. Russell Sherman, retiring president, Newark, presided at the meeting.

R. D. HARLEY, M.D.
Public Relations Chairman

Who Gets the Voluntary Health Contribution?

In 1953, the American public contributed about 4½ billion (that's right, *billion* not million) dollars to religious, humanitarian, health and welfare causes. Religious institutions and agencies received about 2¼ billion of this. Health agencies and analogous resources received about one billion dollars. The top dozen in terms of receipts were:

	Millions
National Foundation for Infantile Paralysis	\$51.5
National Tuberculosis Association	23.9
American Cancer Society	19.8
American Heart Association	10.5
National Society for Crippled Children and Adults	7.8
United Cerebral Palsy	6.4
Muscular Dystrophy Associations of America	4.0
Sister Elizabeth Kenny Foundation	3.4
National Fund for Medical Education	2.5
Arthritis & Rheumatism Foundation	1.4
Damon Runyon Memorial Fund for Cancer Research, Inc.	1.2
Planned Parenthood Foundation of America	1.1

Public Relations Program

The Public Relations program for the year is stressing personal responsibility.

It is becoming increasingly apparent that our day by day relations with the public are one of the most important facets of our public relations program. Every member should deem it a privilege to serve the community in whatever way she can. She may cooperate with other groups that are interested in health such as, P.T.A., women's organizations, church groups and civic activities.

To be a well informed Auxiliary one should read both the *Bulletin* and the *Newsnote*. *Today's Health* also is a good source of Public Relations.

Rural-community health programs bring a great deal of information to the community.

The purpose of each committee is to make

available to the public at the request of the county medical society the various health services.

This year we are also asked to stress traffic and home safety. The increased accident rate in both fields is cause of concern for everyone.

Most of our knowledge is gained through sight such as reading, posters, television, and pamphlets. Along this line Salem County has distributed to all doctors and dentists in Salem County material on the referendum on Medical-Dental College.

Each county has been sent a packet containing programs suggested by the A.M.A. that can be used jointly at Auxiliary-lay meetings.

MRS. SYDNEY G. FINE, Chairman

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Illustrated Review of Fracture Treatment. By F. L. Liebolt, M.D. Pp. 221. Los Altos, California, Lange Medical Publications, 1954. (\$4.00)

This is a welcome addition to the many authoritative publications in the field of fracture treatment. Dr. Liebolt reviews (with profuse illustrations) the anatomy, diagnosis and treatment of almost every variety of fracture. Anatomy, physiology and the process of bone healing of fractures are aptly included. The chapter on fractures of the head and face are particularly welcome. The entire work is extremely well illustrated with long-hand drawings and radiographs. Particularly vivid are the drawings of the mechanisms of the trauma producing each fracture. This paper-back manual with its very fine print and coarse paper is worthwhile for the libraries of medical students, nurses, general practitioners, orthopedists and traumatic surgeons. It should be part of the equipment of every first aid and rescue squad. The author and publisher should be encouraged to print the succeeding editions in the best of book materials.

SIDNEY KEATS, M.D.

Hormones in Health and Disease. Edited by R. L. Craig. New York, The Macmillan Company, 1954. (\$6.00)

This is a thorough and clear review of a large group of endocrine problems with data and bibliographies well up-to-date. It is also intelligible to those seeing only an occasional case of endocrine disorder. Dr. Albright's lecture is a masterful example of perfect teaching. Not one word is missing; not one word is in excess. We are vigorously reminded not to lose our "common sense" when dealing with endocrinology.

The adenohypophysis is discussed with the attention focused on ACTH. The review of the pituitary-adrenal system is complete. Curiously, there is not a single reference to Se'ye's "General Adaptation Syndrome" during the detailed discussion of the role of ACTH in inflammatory disease. The neurohypophysis and water excretion are discussed by van Dyke. Experimental and theoretical data are clearly correlated. Dr. Kendall's chapter discussing the stages of the history of our knowledge of the adrenocortical hormones shows how fascinating scientific history can be. A sound warning is given

to the overzealous medicator, a category still too large among us.

Dr. Soffer's chapter on diagnosis establishes two main facts: (1.) There are clearly defined tests with excellent clinical value. (2.) No laboratory test will replace the critical appraisal and diagnostic acumen of the physician.

The *Endocrine Control of Metabolism* is the title of a chapter which only the exceptionally well-trained biochemist will be able to follow.

Dr. Ragan's lecture on the Use of ACTH and cortisone should be *must* reading for every practitioner. He stresses the side effects. The final outlook for the patient should be our guide in the use of these substances which are far from innocuous. "The patient must know the hazards and should approach the therapy as a calculated risk."

Metabolic effects of insulin by De Witt Stetten is one of the most intelligible and clearest reviews of the physiology of insulin this reviewer has seen. Terms as difficult as simple protein, polypeptides and Krebs cycle suddenly become living objects and a difficult subject is clearly understood even by those whose organic chemistry study is far back in the past.

This reviewer cannot always share the pessimism expressed by Dr. Taylor in his discussion of the use of steroids and gonadotropins in gynecology. I agree that this is the most abused field of hormonal therapy, but with good clinical judgment and by refraining from generalization, results are often excellent when the indications appeared to be only empirical. The statement that the aborted conceptus is in the great majority of cases anatomically defective will not be accepted by everybody.

I recommend this symposium to the endocrinologist as a stimulant, to the internist as an excellent review, to the general practitioner as a clear guide.

ALEXANDER KEYSSAR, M.D.

Surgical Urology. A Handbook of Operative Surgery. By R. H. Flocks, M.D. and David Culp, M.D., State University of Iowa. Pp. 392 (with 567 illustrations on 118 plates). Chicago, Year Book Publishers, Inc. (\$9.75)

This book is one in the series of Handbooks of Operative Surgery. The illustrations, by Paul Ver Vais, are clear, unobstructed by unnecessary detail and done in beautifully contrasted black and white penwork. These illustrations are, in my opinion, the best part of the book, especially for the practicing urologist who will have to consult more detailed literature when in search of description of urological surgical technic.

The text contains much valuable information. It is necessarily limited by the handbook format and suffers sometimes from excessive brevity. All in all, however, this worthwhile addition to the urologist's library should prove helpful to any physician interested in urology.

ALBERT GRUNBERG, M.D.

Progress and Problems in Mental Hospitals: Proceedings of the 1953 Mental Hospital Institute. Edited by Daniel Blain, M.D. and Stella B. Hanau. Washington, 1954. American Psychiatric Association. Pp. 204 with index. (\$2.50)

Each year the country's psychiatrists have learned to look forward to this useful volume. Eschewing all purely theoretical concepts, this is a down-to-earth monograph on how mental hospital administrators actually meet their day by day problems. In psychiatry the glamor seems to be in private practice with psychoneurotics, preferably with the milder cases that do not so desperately need help. The psychotic—particularly the one sick enough to require care in a public hospital—does not seem to have much appeal and our state hospitals are nearly all understaffed and overcrowded. Every one agrees that this is too bad and that public opinion ought to be aroused and that state hospitals ought to have bigger budgets and more staff. But outside of the administrators themselves, no one seems to do much about it.

Here is the record of what the hospital administrators are doing. Here they exchange ideas. For the most part, the text consists of verbatim transcripts of what the participants said. It was unrehearsed, and it has the sparkle of spontaneity as well as the shrewdness of actual living experience. The editing is so skillful that the reader is not conscious of the way in which the "ers" and "ahs" and repetitions and errors have been smoothed out.

The much harassed hospital officials who have, in effect, "written" this book with sound recording devices all manage to retain their sense of humor, sense of proportion and sense of the possible. The only jarring note is Mr. Weihofen's insistence on calling patients "inmates." Somebody ought to tell him.

HENRY A. DAVIDSON, M.D.

Uses of Wine in Medical Practice. By S. P. Lucia, M.D. Pp. 42. Published by the Wine Advisory Board, San Francisco, 1954. Gratis.

Wine resembles gastric juice more closely than does any other natural beverage. It relieves the pains of angina pectoris and Raynaud's disease. It increases diuresis. It brightens otherwise monotonous diets. "It has been found of value in a wide variety of illnesses, by producing euphoria." It stimulates the appetite and it is "the safest of all sedatives." It has strong bactericidal action. It says all this and much more in this brochure. While not a book of verses to be read under the bough with thou, this is an interesting if somewhat one-sided presentation of the virtues of wine. And all it says may well be true. In vino veritas—why not?

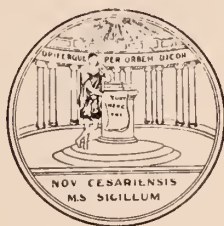
SAMUEL POLLACK, M.D.

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Editorial Office
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- † Obituary
- e—Editorial
- br—Book Review
- ab—Abstract

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Bed Rest in the Treatment of Tuberculosis

A Statement by the Committee on Therapy of the American Trudeau Society. The American Review of Tuberculosis, June, 1954.

The continuing reports showing the increased effectiveness of antimicrobial therapy in the treatment of pulmonary tuberculosis have caused many physicians to question the necessity or advisability of prolonged bed rest.

This has been further accentuated by the featured publication in newspapers and magazines of proposed clinical studies, although no such studies have in fact progressed to a stage which permits even preliminary conclusions to be drawn. Programs for the treatment of unhospitalized patients are frequently misnamed and misinterpreted as "ambulatory" treatment programs, as opposed to bed-care programs. In actuality, such programs are designed to supplement hospital care of patients, rather than to replace it by: (1) commencing antimicrobial therapy before hospitalization can be effected in communities where there is shortage of hospital beds; and (2) continuing long-term drug therapy after control of the disease has been effected by hospital treatment. Even when home care is substituted entirely for hospital care by organized outpatient services, provision is made for bed care in the home. The designation of programs of this type as "ambulatory" presupposes an abandonment of the principle of rest therapy which is not intended and is not yet, at least, recommended by any official group.

The Committee again states that, from the facts now available, there is no evidence to support a reduction in the amount of rest therapy from that of past practices except as this may be justified by an earlier attainment of an inactive

status of the disease. There appears to be no doubt that antimicrobial therapy has materially shortened the period of recovery in the average case of tuberculosis, and that it has greatly decreased the case mortality rate. This does not necessarily imply, however, that it has altered the indications for rest therapy during the active phases of the illness.

The studies which are in progress to determine to what extent bed rest may be safely dispensed with, or in what categories or stages of the disease it may play an unimportant role in therapy, will require a long period of study. Until these studies are completed, the clinician will be well advised to adhere to the established indications for bed care. Essentially, these consist of relatively complete bed rest in accordance with previously accepted principles, until all symptoms have cleared, all cavities have been lost to view roentgenographically, all regressive infiltrations have reached an unchanging status, and sputum or gastric washings have become negative for tubercle bacilli by direct examination and culture. From this stage, gradual physical rehabilitation by progressive mobilization of the patient is permitted and is usually so graded to restore him to relatively normal activities no sooner than in six to twelve months. The total period of disability, although greatly shortened on the average, must still be estimated even in relatively mild and favorably responding cases as a minimum of one year. Even after this, the usual protective restrictions as to character and hours of work and the avoidance of strenuous exertion or fatigue must be observed for at least several years. The continuation of antimicrobial therapy itself for a total of one and one-half to two years is commonly recommended, but infor-

mation is not yet available with respect to whether this provides adequate protection to permit any shortening of the convalescent period.

The indications for rest therapy during the active phases of tuberculosis are not altered by the proposals that patients may subsequently be treated with either surgical collapse or resection. A preliminary period of bed rest, combined with antimicrobial therapy, until all symptoms have cleared, cavities have diminished in size, or remain unchanged, and infiltrations have reached a relatively unchanging status is suggested. A continued period of rest after the surgical therapy is completed until it is evident that sputum or

gastric washings will become and remain negative by culture and that the patient be symptom free should be used. From this stage, gradual physical rehabilitation for a period of several months, with the usual further protective restrictions, is indicated.

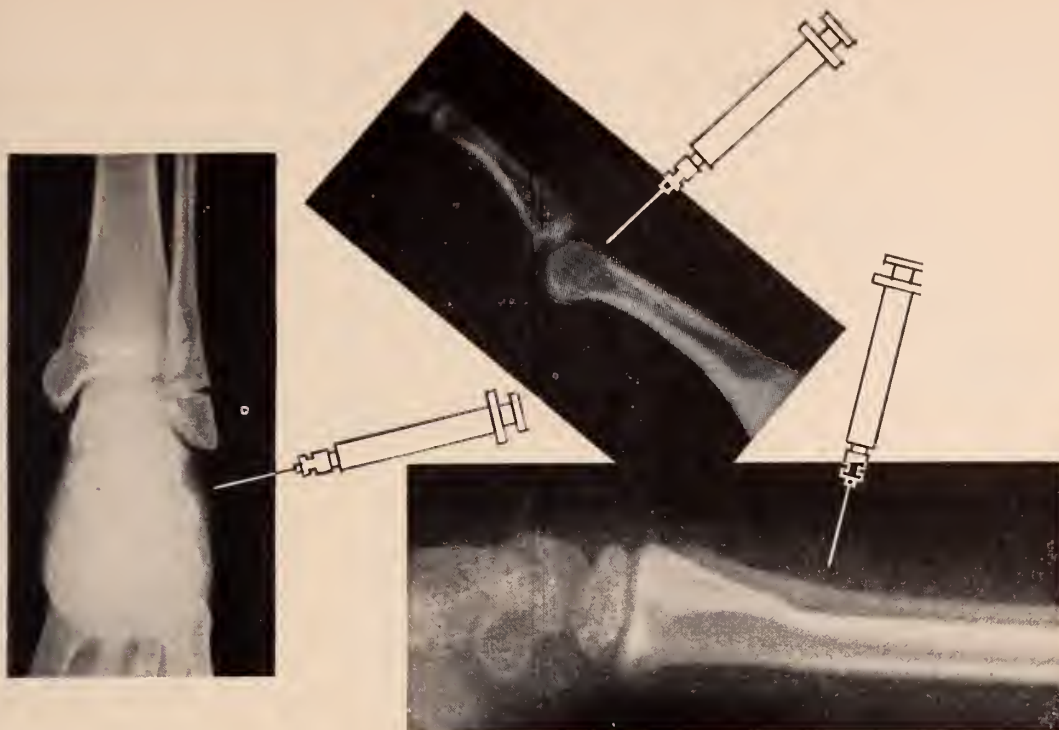
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1. MacAusland, W. R., Jr.; Gartland, J. J., and Hallock, H.: The Use of Hyaluronidase in Orthopaedic Surgery, *J. Bone & Joint Surg.* 35-A:604 (July) 1953.

2. Swenson, S. A., Jr.: Minor Surgical Aspects of Closed Wounds, *Am. J. Surg.* 87:384 (March) 1954.

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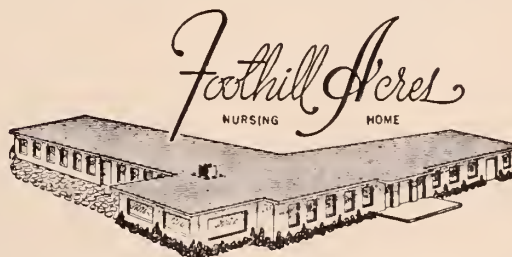
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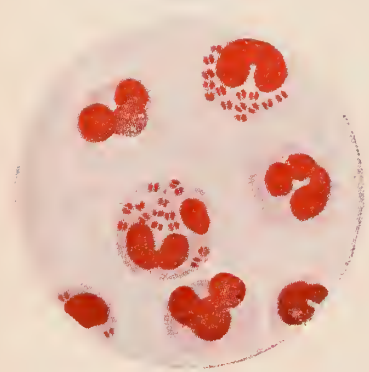
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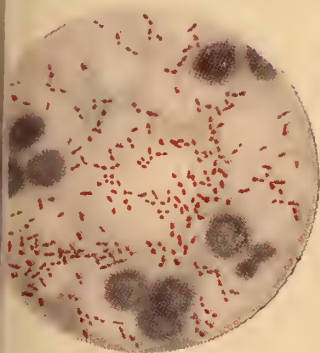
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(1) Yow, E. M.; Taylor, F. M.; Hirsch, J.; Frankel, R. A., & Carnes, H. E.: *J. Pediat.* **42**:151, 1953. (2) Dodd, K.: *J. Arkansas M. Soc.* **10**:174, 1954. (3) Hanbery, J. W.: *Neurology* **4**:301, 1954. (4) Miller, C.; Hansen, J. E., & Pollock, B. E.: *Am. Heart J.* **47**:453, 1954. (5) Keefer, C. S., in Smith, A., & Wermer, P. L.: *Modern Treatment*, New York, Paul B. Hoeber, Inc., 1953, p. 65.



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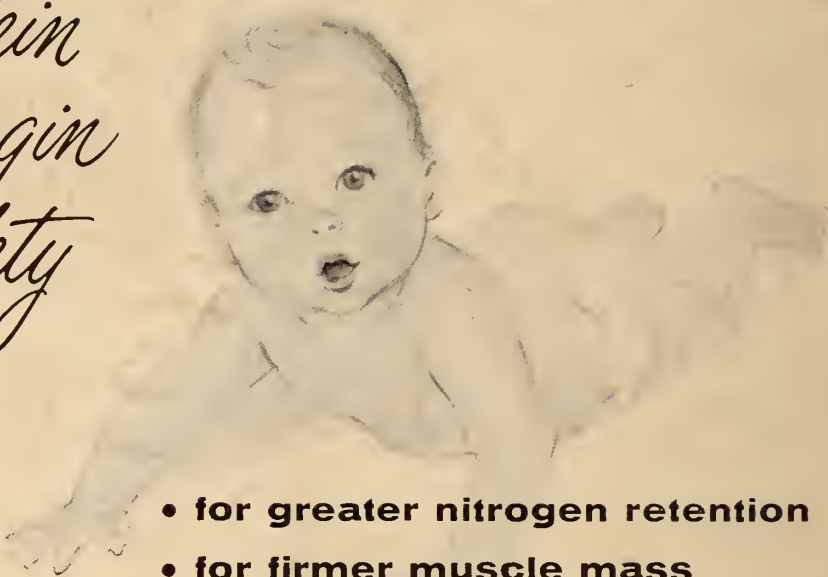
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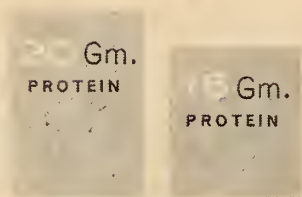


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1. Jeans, P. C., in A.M.A. Handbook of Nutrition, Philadelphia, Blakiston, 1951, pp. 275-298. 2. Stare, F. J., and Davidson, C. S., in The Proteins, American Medical Association, 1945.

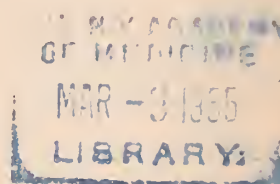
The 188th Annual Meeting
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Haddon Hall, Atlantic City, New Jersey, May 16, 17, 18, and 19, 1954

THE OFFICIAL TRANSACTIONS

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HOUSE OF DELEGATES

Session I

Sunday Afternoon, May 16, 1954

The 188th Annual Meeting of the House of Delegates of The Medical Society of New Jersey convened at Haddon Hall, Atlantic City, at 2:40 p.m., Dr. Henry B. Decker, President of the Society, presiding.

PRESIDENT DECKER: The House of Delegates will be in order. The invocation will be pronounced by the Reverend William F. Parker, Pastor of the Olivet Presbyterian Church in Atlantic City. Reverend Parker is also President of the Absecon Island Ministerial Association.

(Rev. Parker then gave the Invocation.)

PRESIDENT DECKER: Mr. Secretary, is there a quorum present?

SECRETARY GREIFINGER: Mr. President, a quorum is present.

PRESIDENT DECKER: Dr. Mulligan, will you report as Chairman of the Committee on Credentials?

DR. LUKE A. MULLIGAN: We have had no controversy on the Committee on Credentials.

PRESIDENT DECKER: Thank you. Dr. David B. Allman will serve as Parliamentarian. Dr. Lee and Dr. Corio are Sergeants-at-Arms.

The personnel of the Reference Committees are published in the program.

If there is no objection, the minutes of the 1953 meeting will be approved as published in the August, 1954 JOURNAL of The Medical Society of New Jersey. I hear no objections. The minutes stand approved as published.

We have some honored guests in the House today. I am going to ask Dr. Murray to escort the guests from the New York State Medical Society.

(Dr. Murray and guests came to platform.)

May I introduce Dr. Andrew A. Eggston, who is President of the Medical Society in the Empire State; and Dr. Walter P. Anderton, who is Secretary and Delegate to the Society? (Applause)

DR. EGGSTON: I presume that it is customary for me to say a few words. I certainly want to extend my appreciation for this wonderful invitation to be with you. It is always a pleasure to travel through New Jersey, from the mountains and the rolling fields and the farms down to the seashore. I don't know of any

greater variation in terrain and anything that is more pleasant than both sides and every side of this state.

We just had a meeting in New York last week. We just got through a rather strenuous time—a lot of questions and problems to discuss. I don't know how many we solved, but we tried; and it was altogether a very successful meeting, as it is usually in New York City.

There are many things that I know you want to help with in cooperation with other states. First, our press relations. These are most important. I think they have been neglected in the past. We discussed that at great length and had several conferences with the press. Our press relations have been bad; so have our press reports. Sometimes the press maligns a great and wonderful profession through ignorance or by design. It behooves us to take a little different philosophy of our existence in medicine and to counteract this bad publicity. We have no reason to be condemned; we have no excuses to make. Most doctors try to do an honest job; they do the best they can. They sacrifice time and energy, mentally and physically. You never hear of the good things they do in emergency cases and accidents and surgery and so on. You do hear of the bad things, perpetrated by a few black sheep in the profession. Sometimes the press suggests that we won't do anything about this. Well, through education and ethics and being sensible in good philosophy, in good medicine, we can do something about it; but that takes time.

One other problem is that of interns and residents in the small hospitals. What are we going to do about them? I live in Westchester County. We have twelve hospitals there. We have hardly a single graduate of an American school as intern or resident. There is something wrong with that situation. Somehow or other I hope you will help to find the solution.

Again I greet you. I hope you have a wonderful and successful time. You are always welcome to the Medical Society of New York City. Thank you very much.

(Applause)

PRESIDENT DECKER: Thank you, Dr. Eggston and now I call on Dr. Anderton.

DR. ANDERTON: Mr. President, whenever I have to make a speech I become embarrassed but it gives me pleasure to bring you greetings

from the Medical Society of New York with best wishes for a very successful meeting. (Applause)

PRESIDENT DECKER: Dr. Reuling, a delegate to this Society from New York.

Dr. JAMES R. REULING: I bring you sincerely the greetings from the Medical Society of the State of New York. I am going to stand here and admit that The Medical Society of New Jersey is the oldest medical society in this country. (Applause)

There are things that we want to do and have to do. It reminds me of a story. I said to a friend of mine: "Where have you been?" He said: "I was just up in New Hampshire." "What were you doing up there?" He said: "I had to go to attend my uncle's wedding. He was 92 years old." I said: "What did he want to get married for?" Well, he said: "He didn't want to; he had to." (Laughter)

It's nice to be here. I wish you a very successful meeting. (Applause)

PRESIDENT DECKER: Thank you, Dr. Reuling.

Dr. Blaisdell is going to escort the gentlemen from Connecticut.

Dr. Gildersleeve, President of the Connecticut State Medical Society. (Applause)

Dr. GEORGE H. GILDERSLEEVE: President Decker, Members of the House of Delegates: It is a privilege to be here at the 188th Annual Meeting of The Medical Society of New Jersey. At this time I bring you the best wishes and the greetings of the Connecticut State Medical Society. I sincerely wish you a very, very successful meeting. I thank you for inviting me. (Applause)

PRESIDENT DECKER: Thank you.

Dr. Bradley, who is a Delegate to this Society from the Connecticut State Medical Society. (Applause)

Dr. E. TREMAIN BRADLEY: President Decker, Members of the House of Delegates: It is certainly a pleasure to be here. I feel a little differently than going to New Hampshire. Going to New Jersey is not something which is necessary; but it is a great pleasure. Atlantic City is a real vacation spot and a wonderful place to hold a meeting, and it certainly is grand to be with you all.

May I officially bring the good wishes of the Connecticut State Medical Society to The Medical Society of New Jersey. It is a pleasure to be here. (Applause)

PRESIDENT DECKER: Thank you.

Dr. Whitehill is President of the Medical Society of the Commonwealth of Pennsylvania. (Applause)

Dr. JAMES L. WHITEHILL: Dr. Decker, Members of the House of Delegates: I bring you greetings and best wishes from the officers and Board of Trustees of The Medical Society of the State of Pennsylvania, and I wish you all success in the world in your meeting here this year.

We are planning in Pennsylvania some day to change our place of meeting to Atlantic City, but we haven't won them over completely yet. We hope some day we can also meet at Haddon Hall in Atlantic City. (Applause)

PRESIDENT DECKER: Of course, we object very strenuously, particularly Dr. Allman, to having the Pennsylvania Medical Society meet in Atlantic City.

One of the compensations of teaching that is imponderable or intangible is meeting young men who are in the formative years and obtaining ideas from them and hoping that some of your experience rubs off on them. I took the liberty of inviting the President, or he was President until last week of the Student American Medical Association of Jefferson Medical College today. He is also President of the senior class and within a period of a few weeks will be graduated.

Dr. Sharp will bring Mr. Dickersin up, and see if you don't agree with me that there are compensations, other than material, in teaching. (Applause)

MR. G. RICHARD DICKERSIN: Dr. Decker and Members of the House of Delegates of The Medical Society of New Jersey: It is indeed a pleasure to be invited here. I want to thank Dr. Decker and the Society for inviting me.

I think that inviting student representatives to meetings of state medical societies is a good idea. Students who are given the opportunity to get interested in organized medicine will display that interest. This has been proved over the last two years in the National Student American Medical Association.

This organization now encompasses most of the medical schools in the United States and most of the students in those schools. Our executive secretary is a paid member of our staff. We have our own executive council, comprised of students elected from all over the country. We have our own student journal. We have our own conventions.

Actually, if this organization can accomplish one thing, it will have been a worthwhile organization. That one thing is to introduce to the students the thought of keeping in contact with his fellow-doctors after he is graduated. It is the thought of taking part in organized

medicine rather than taking a back seat and living by himself.

I again want to thank Dr. Decker and the Society for inviting me today. (Applause)

PRESIDENT DECKER: We have another guest to be introduced to the Society. We have met him many times before. I thought that he had been officially invited until some few weeks ago he reminded me that he had received no official invitation. I immediately invited him; and this and that other stuff, and wound up, as we frequently do in our correspondence, by telling him where to go. He replied that he had received the invitation; he would comply with my request to go to, and attend the meeting of The Medical Society of New Jersey. So that you can quickly realize what dentists think about our meeting.

This is Dr. John G. Carr, who is Secretary of the New Jersey State Dental Society. (Applause) You are limited to a minute and a half.

DR. CARR: As a self-invited guest, I'll invite myself to three minutes. (Laughter)

Dr. Decker and Members of the House of Delegates: One of the pleasant experiences of being an officer in a professional society is that of receiving invitations to meet with like associations. When the office is a continuing one, such as mine is, and the invitations are repeated, the pleasure multiplies.

This is the third time that I have had the pleasure of meeting with you. For the past two years I have met regularly with your Welfare Committee. I have attended many of your committee and other functions, and on many occasions I have been invited to sit at your table and break bread with you. So I come not at all as a formal invited guest, but rather as a friend of the family and feel very much at home in your home.

One thing that has impressed me over the time that I have held office is the increasing importance of professional organizations and the tremendous potential they have in doing good. In this world of ours, which is perhaps becoming more complex (and maybe we are making it that way ourselves) the time has long since passed when people can live individually in a vacuum. I would make a plea with you that you determine to devote some of your time and efforts and intelligence to the benefit of your professional association.

Before I forget my manners, I would like to bring you greetings from the New Jersey State Dental Society and every good wish for a successful meeting. Personally, I would like to thank you for giving me this opportunity of another pleasant experience, and I should also like to express my gratitude publicly for the

many, many courtesies extended to me by your President, Dr. Decker. You will look a long time before you find a better President, either north or south of the Rancocas. Thank you. (Laughter and applause)

PRESIDENT DECKER: Dr. Carr, if he has been looking at this House of Delegates, may have seen many faces of men who are just as well, if not better, qualified to hold this position than I am. But as a dentist, he is biased.

Now I am going to interrupt the order of business to make a few remarks. This will be the last time that you have to sit and listen to me. I want to thank the Society for the privilege of having served as President. It was a position that I sought as part of my plan of life. I have enjoyed it completely. You have made it very pleasant for me this year. Much of that has been due to the efforts and activities of the various committee chairmen and the members of the Society who served on those committees. We have had a relatively harmonious year; no difficulty that could not be straightened out with a minimum of effort.

Much of this also has been due to the administrative staff. No one in the Society, unless they have held office or have been active on one of the subcommittees, can appreciate the tremendous amount of help that the administrative staff give to an officer, the tremendous amount of work that they do. I am not going to mention them all by name—Mrs. Madden and Mrs. Armstrong particularly.

We have an Executive Officer who has a remarkable felicity for words. A chap who is busy practicing and is requested to have a column or two prepared within the next three or four days on a subject with which he is very vaguely familiar, is sometimes in a dither. Mr. Nevin promptly takes care of that and when the officer reads it he is very much surprised at how well he writes.

There are certain problems in the functioning of the Society. I had some inkling of those last year when I suggested that possibly the House of Delegates might meet more frequently. We have become unwieldy with advisory committees. The advisory committees are frequently composed of specialists who see a small part of the picture, their small part, and it takes frequently an interminable time for affairs to be settled. I feel that the original purpose of the advisory committees has somewhat been submerged or lost in their activities. Dr. Lance has prepared a plan that, I hope, will work, which he will introduce. It may seem radical to many of the members but it is within his province to put it into operation. I hope that there is not too much argument about it when it does come forth.

We have attempted during the last year—remembering the John Donne sermon that no man is an island—to cooperate with many organizations. We have set up liaison committees. They have functioned very well. We have had trouble in one of them, but I think that in time will be straightened out. But our association with other professional organizations in the state, I feel, is, with one exception, at about as high a level as it has ever been.

We have excellent relations with the Legislature. Dr. Blaisdell instituted a plan which went into operation two years ago, of local contact with the legislators by members of the county medical society. This has brought about a better understanding with the Legislature than, I think, has ever existed before. The differences that we have about various bills are discussed at the local level with the legislators rather than in Trenton. Legislators will listen to men in their own community whom they respect. I would call your attention to Dr. Blaisdell who has served as Chairman of this Legislative Committee most efficiently and served the Society well.

Now, if you read Somerville's condensation of Toynbee's history, you will recall that to accomplish something a nation must undergo a series of frustrations. In my particular plan of life I had envisioned a medical school in New Jersey. I had hoped that while I was President of the Medical Society legislation might be introduced that would permit the voters to vote upon such legislation. That is one of my frustrations.

You will recall several years ago that Dr. Schaaf requested the Governor to appoint a commission to study the need of such a medical school. This commission made the study and reported that there was a need. The Medical Society of New Jersey, as its policy in 1946, determined that a medical school in New Jersey, to be approved by the Medical Society, must be a Grade A medical school; it must be associated with an approved university, and it must be supported by state money or municipal money. We realized that private medical schools were inadequately supported. Practically every medical school in the country receives aid from some tax money, and that is increasing. In New York, two of the medical schools have been taken over by the state—Long Island Medical College and Syracuse University Medical College. In Pennsylvania the Legislature appropriates almost fifteen hundred dollars per year per student in each medical school in the state. I think they spend about five million dollars a year to educate medical students there. That pays part of the cost.

Now, during this time we have been engaged in studies of this thing. We have drawn up bills to permit a referendum and we hope that those bills will pass. They are now in the Legislature. We hope they will pass so that next November the taxpayers will have an opportunity to vote on this.

As our policy is set up, the only institution in the state that can qualify for our support is the State University of New Jersey, Rutgers University. As one travels throughout the state one hears all kinds of questions about this. It becomes apparent that few of our citizens know very much about our universities.

Of the seven or nine continental colleges originally set up, two of them were in New Jersey; no other state had more than one. Queens College, which is presently Rutgers or the State University of New Jersey, and Princeton. Princeton was called the College of New Jersey until the beginning of the 19th century. It was set up first at Elizabeth, then at Newark and finally at Princeton. Princeton was set up as a training school for Presbyterian ministers. Rutgers was set up as a training school or a college for Dutch Reform ministers. Princeton continued as such a school until the early part of the last century when they separated from the seminary. Rutgers continued that way for just a few years. Then in the early 1800's they were separated from the Dutch Reform Seminary. So that when the land grant money became available in the 1860's Rutgers was selected by the State Legislature to be the land grant college of New Jersey. About six years ago a bill was passed by the Legislature to clarify Rutgers' status as the State University of New Jersey.

So that you can assure people who ask you, the State University of New Jersey is a non-sectarian institution. And we feel that a medical school should be a non-sectarian institution because freedom is the most important thing in medical teaching.

Now, may I again thank you for permitting me to serve as your President; and we will resume the regular order of business.
(Applause)

Now we have annual and supplemental reports, copies of which are in your hands. May I have a motion that these reports be referred to the designated Reference Committees?

DR. JEROME G. KAUFMAN: So moved.

(The motion was seconded.)

PRESIDENT DECKER: It has been moved and seconded that these reports be referred to the proper Reference Committees. All those in favor? Opposed? So ordered.

Are there any additional reports that have not been sent in for printing or distribution?

We have no report from the Laboratory Medicine Committee.

If you have read the budget and the request for an increase in dues and wish to question Dr. Allman, I'll be glad to ask him to answer any question that you want to ask.

If you require Dr. McCall to elaborate on the Treasurer's report, I will ask him to do so.

Hearing no question, we assume that you know all of the answers.

Now, under New Business we have some resolutions which have been received. Printed copies are in the folders of the Delegates.

Resolutions have been received from the Union County Medical Society concerning certain bills now pending before the Congress. They concern S. 3114, and H.R. 6949, 6950 and 8356. These are referred to Reference Committee "E."

(See Appendix 1 and Appendix 2)

Resolution opposing the expansion of Social Security and the inclusion of physicians in the Social Security System also to Reference Committee "E."

(See Appendix 3)

Resolution supporting the proposed 23rd Amendment also to Reference Committee "E."

(See Appendix 4)

Resolution supporting action to determine the position of candidates on the Bricker Amendment and proposed 23rd Amendment, also to Reference Committee "E."

(See Appendix 5)

The resolution from Mercer County opposing any change in the present procedure of payment of fees by Medical-Surgical Plan, to Reference Committee "C."

(See Appendix 6)

A resolution from Gloucester County concerning group participation in New Jersey Blue Cross through the Medical Society, to Reference Committee "C."

(See Appendix 7)

A resolution from Sussex County concerning tests for drunken driving, to Reference Committee on Miscellaneous Business.

(See Appendix 8)

A resolution from an Essex Delegate concerning the Medical-Surgical Plan, to Reference Committee "C."

(See Appendix 9)

There is also in your folder a resolution from Essex County concerning the pension plan for the employees of the Medical Society. That goes to Reference Committee "B."

DR. JEROME G. KAUFMAN: Mr. President, the Essex County delegation would like that one read to the House of Delegates.

PRESIDENT DECKER: The Essex County delegation would like that read. Will the Delegate from Essex County, who has that resolution come forward and read it?

Dr. Kaufman read the resolution calling on the Trustees to review pension plans for employees of the Society. This is detailed in Appendix 10.

PRESIDENT DECKER: Thank you, Dr. Kaufman. That will be referred to Reference Committee "B."

There is still another resolution concerning the Medical Service Administration. That will go to Reference Committee "C." That is in your folder.

Now, are there any resolutions from the floor?

Speaking for the Hudson County Medical Society, Dr. Charles L. Cuniff read the resolution which now appears as Appendix 11.

PRESIDENT DECKER: That will be referred to Reference Committee "C." Any more resolutions?

Dr. Hahn, Essex, read a resolution on rehabilitation. This appears as Appendix 12.

PRESIDENT DECKER: This resolution is referred to the Reference Committee on Miscellaneous Business. Any more resolutions? . . . Any memorials? . . . Any proposed amendments to Constitution or By-Laws?

Are there any miscellaneous matters not yet covered? (no response.)

I ask you all to visit the technical exhibits and sign a card. Urge all of the visitors to the meeting to do it because the cost of this meeting is largely carried by the exhibitors. I also urge that banquet tickets be purchased early.

Now we go on to the interesting part of this meeting, which is an open discussion on the Medical-Surgical Plan. Edith writes at the end of this: "Now you're on your own."

My parliamentarian tells me this is supposed to be in the nature of a free-for-all. Apparently anyone who wants to can come up to the podium and express himself at length and in detail, ask any questions that he wants. We can not guarantee adequate answers although we will try to get them from Dr. Borsher.

Before we go on to this, may I have a motion for adjournment of the House of Delegates until tomorrow afternoon?

DR. JEROME G. KAUFMAN: I so move.

(The motion was seconded.)

PRESIDENT DECKER: Are you ready for the question? All those in favor? Opposed? The House of Delegates is adjourned.

Dr. Schaaf will preside at this informal discussion.

DR. SCHAAF: Dr. Decker, Fellow Members of The Medical Society of New Jersey, and Guests: It is a privilege to represent the Medical-Surgical Plan today at this open session. I hope that after we have made a few brief comments and some introductory remarks you will feel free to ask questions and we will do our best to answer them.

I would like at the moment to introduce Dr. Irving P. Borsher, the Executive Vice-President and Medical Director. Sitting next to him is Mr. Albert J. Durgom, Executive Director of the Hospital Service Plan of New Jersey; and our old friend and confrere, Mr. James E. Bryan, former Executive Officer of The Medical Society of New Jersey and now Administrator of our Plan. On his right, Mr. Smith, who is the Assistant Administrator.

We will open the meeting by referring you to the annual report which appears in the May issue of the JOURNAL of the Society and also to the supplemental report placed in your hands* this afternoon. The latter contains an outline of what has happened since we submitted our original report in March.

At the meeting last year, the Society conferred authority upon the Board of the Medical-Surgical Plan of New Jersey to bring about certain changes in the policy. We are still operating under the same contract we had a year ago. A great deal of water has gone over the dam since that time and some of you may be disappointed by the fact that we are not yet able to offer you a new contract with a new subscription rate, the new contract to include the recommendations which were referred to us by you last year. There are adequate reasons for the delay. As the meeting progresses we will bring out the various points that are of concern to all of you.

Now, with that very brief preamble, I would like to have some one from the floor open the discussion by asking any question that might be in his mind.

DR. RAYMOND A. TAYLOR (Ocean County): Doctor, I would like to inquire why the Medical-Surgical Plan is so slow in processing renewals of our contracts. For instance, my own

contract ran out in December. To date I have not received another renewal card and for three months afterward I did not know whether I was in good standing or not. And speaking as a person that doesn't know too much about the mechanics of the Plan, it seems rather a haphazard way of running a business.

DR. SCHAAF: You are speaking of the Hospital Service Plan?

DR. TAYLOR: No. The Medical-Surgical.

DR. SCHAAF: You are not insured with the Medical-Surgical Plan unless you have a direct enrollment policy. You have one?

DR. TAYLOR: Yes.

DR. SCHAAF: That was under the enrollment of June 1950?

DR. TAYLOR: Long before that.

DR. SCHAAF: It only ran six weeks enrollment for the Medical-Surgical Plan.

DR. TAYLOR: I was in on that.

DR. SCHAAF: I will ask Mr. Durgom if he can give you an answer because the Hospital Service Plan conducts our enrollment and all of our correspondence in relation to contracts.

MR. DURGOM: The matter of issuing contracts with respect to the Medical-Surgical Plan would not involve issuing a new one each year on renewal of enrollment unless there happened to be a new form of subscription contract authorized to be placed in force in place of the old one. Therefore, on the anniversary of last December, you would not be concerned in getting another contract in the Medical Plan because it will be still with one noted as Series 1949-X. If, on the other hand, it was a matter of your Blue Cross enrollment—I wonder whether, Doctor, you may be referring to a Blue Cross contract in December being renewed.

DR. TAYLOR: No, I'm not. I'm referring to the Medical-Surgical, and I even wrote in on two occasions inquiring about my standing and finally I received a letter stating that if I would send in a certain sum I would be enrolled, but that was about three months afterwards. In the interim I had no knowledge as to whether I was in good standing or not.

MR. DURGOM: That would be a matter of billing situation as to the status of your enrollment, whether your contract was paid up from our records.

DR. TAYLOR: I'm not the only one and I am wondering if something is being done about the business end of this proposition to give the clients better satisfaction as to where they stand.

MR. DURGOM: If you will give me, at the end of this meeting, the contract number, your

*Printed here as Appendix 13.

name and address, I will be very happy to get a report directly to you on the status of your contract; and the same would apply to anyone else among you if you do have any question with respect to the enrollment status or billing status. We do go into those matters when we are given the contract number.

DR. LEONARD S. ELLENBOGEN (Atlantic): I am a radiologist and therefore I have more than one question to ask.

The first deals with the payment for x-ray therapy. X-ray therapy plays a vital part in the treatment of many types of cancer. In certain types, it is the most efficient modality. Yet there is no provision for payment of x-ray therapy in the Medical-Surgical Plan.

I should like to discuss two of the answers we usually get. The first is: Yes, we know that x-ray therapy is important in many types of malignancies and we feel that it should be provided for by the Plan; but how would we of the Plan know whom to pay? I'm quoting almost verbatim, because in many hospitals there is a great variance in the mode of payment of radiologists. Some are salaried employees of the hospital, others lease space, and still others are on a percentage basis.

I respectfully submit that it is not the concern of the Medical-Surgical Plan what the physician does with that payment. That is, if the physician is on a percentage basis with the hospital, it is up to him to give the hospital its proportionate share of the fee. If he is on a salary, he may then turn his entire fee over to the hospital. But that question of the method of payment is no business of the Plan which must pay, according to its own statement, the treating physician.

Another answer is that we have no actuarial experience. But when the Medical-Surgical Plan began it employed an excellent actuarial staff. The analyses of costs by these actuaries was extremely close to what happened in actual practice. Why can't this be done for x-ray therapy? Furthermore, at least five of the various state plans *have* provided for payment of x-ray therapy, and certainly an analysis of their experience is readily available to the New Jersey Plan. So much for the matter of x-ray therapy.

The second question concerns payment for emergency x-rays. This was raised at last year's meeting and I have searched the report of the Medical-Surgical Plan for this year in vain for any statement as to what action has been taken on the recommendation of the House of Delegates of last year.

Third, and this is vital to other specialties such as pathology, anesthesiology and physi-

cal medicine. Being a radiologist, I will speak of it in terms of the practice of radiology; that is, the fundamental recognition which has been enunciated time and again by the American Medical Association, by our State Medical Society, that the practice of diagnostic radiology is the practice of medicine. If that is so, and there seems to be no honest medical opinion to gainsay this, then what steps has the Medical-Surgical Plan taken in the past? What steps does it propose to take in the future to bring to radiology and to the other specialties this recognition that in their diagnostic work they are indeed practicing medicine, specifically, by seeking to separate payment for these services from the Blue Cross Plan of payment for "Hospital services."

Now, having run through these three, I will bring up a question: Why has nothing been done, except for a kind and sympathetic word, in the past, about the first three questions raised?

Gentlemen, I submit that the reason nothing has been done is because there is a lack of representation on the Board of Trustees of the Medical-Surgical Plan of any but surgeons and a few internists.

Now, the answer to this has always been a pious: "We cannot accept any divisions in medicine. The members of the Board of Trustees of the Blue Shield speak for all physicians."

This is as realistic and as democratic as having ninety-six senators who are all cotton growers and expect them to act efficiently and promptly on the needs of the dairy farmers of Wisconsin, the coal miners of Pennsylvania, and the great masses of factory laborers. It does not happen that way, and we who should know something of human relations must appreciate that.

And so I conclude this group by asking whether, and if not why not, there are any plans for broadening the scope of representation of the different medical specialties on the Board of Trustees of the Blue Shield. (Applause)

DR. SCHAAF: I am going to ask Dr. Borsher to answer some of the details of this, but I'd like to call attention of the doctor to the fact that three years ago this body declared that it shall not be the policy of the Society to have individual group representation on the Board of Trustees of the Medical-Surgical Plan. That was very emphatically stated here. Actually we have a very fine obstetrician; we have an allergist; we have an ear, nose and throat specialist; we have some surgeons and we have a couple of laymen. So we have very wide representation.

The Medical-Surgical Plan does not make policy. We operate within the scope and field of the existing pattern of medical practice in this state. It is not the Medical-Surgical Plan that differentiates between anesthesiologists and pathologists and x-ray men and physiatrists. That has grown up over the last fifty years. They have become parts of hospital services. To illustrate: there is a certain hospital in Essex County where they issued invitations to physicians in the neighborhood to send in all their x-ray work with the hospital collecting the fees. We tried to have a conference with the president of the Board of Trustees of that hospital. He refused to meet with the committee on the issue which we were about to raise. Those things lie not in the Medical-Surgical Plan; they lie in the existing pattern of practice and in the behavior and attitudes of presidents of the boards of trustees.

Now, so much could be said on it, we can talk from here until tomorrow. We must continue to operate in the existing pattern unless the pattern changes. And as far as the detail is concerned, I am going to let Dr. Borsher take over the actuarial question.

DR. BORSHER: The first question or comment related to the provision of payment for benefits in relation to x-ray therapy. Now, the Plan is aware of the actuarial factors and the costs involved in x-ray therapy, diagnostic therapy, both in and outside of the hospital.

The Radiological Society has had representatives meet in the past with both the Hospital Plan and the Medical Plan. The last meeting was with a liaison committee of the New Jersey Radiological Society in December 1953. The understanding at the end of that meeting was that the Radiological Society would submit to the Medical-Surgical Plan specific recommendations with regard to fee schedules and specific recommendations with regard to x-ray coverage both in and outside of hospital, for study. And to this date there has been no further word from the Radiological Society as to specific recommendations upon which the Medical-Surgical Plan can determine what the cost of the provision for those services based on the recommendations of the Radiological Society would be. That's Number 1.

The recommendation of the House of Delegates last year was that a study should be made of coverage by the Plan for x-ray services in connection with accidental injury. That was the recommendation of the House of Delegates. That study has been made. We have a pretty good estimate of what that cost would be, based on the experience that one Blue Shield plan has had in providing this coverage for nine years.

Actually, if it is related to Medical-Surgical Plan's experience, and this will be an estimate, it would be approximately three per cent of claim costs. We know what the cost of provision for coverage for x-ray services in connection with accidental injury outside of hospital would be.

It cannot be applied under the current contract because there was no provision in the premium for it and it would have to await the issuance of a new contract series with an appropriate premium rate if it were decided to include that particular range of coverage.

Now, as far as Question Number 3 is concerned, the Medical-Surgical Plan is in accord with the resolution adopted by the Board of Trustees of this Society two years ago, to the effect that Hospital Plan should not make payment for medical services rendered by physicians and Medical Plan should not make payment for hospital services.

Now, the practical approach in that is this: until the Medical Plan can make provision for coverage of the medical services of physicians, which are not presently included in the range of services, it is not in the interest of the subscribers of the Hospital Plan, (and there are two million of them), to delete those services presently included, which are not medical services of private practicing physicians but are the services in connection with contractors with the hospital.

DR. SCHAAF: Thank you, Dr. Borsher.

Some one over there had a question. Will you come forward?

DR. PAUL J. KREUTZ (Union): Is it true that the Medical-Surgical Plan contemplates changing the provisions with regard to obstetrical care from a service basis to an indemnity basis?

DR. SCHAAF: Not so far as hospital care is concerned. They propose to delete pre and post-natal care outside of hospital. They are going to delete that; but in-hospital care will be full coverage.

DR. KREUTZ: With the deletion of pre-natal and post-natal care will there also be a diminution in the amount of the fee paid for service in-hospital?

DR. SCHAAF: We now pay \$125, which includes pre- and post-natal care. If we delete that, the fee payment will be \$100 without payment for office or home care prior or subsequent to deliveries.

Who else? Somebody else must have a question.

DR. KENNETH E. GARDNER (Essex): Has anything been considered by the Plan to provide optional services to cover some of these services which cannot be included under normal medical and surgical? That is, a person

who receives normal medical-surgical coverage with the option of taking additional coverage for possibly anesthesia, assistant's fees, and other services which seem to be on the fringe area, possibly even obstetrics might be considered an optional service.

DR. SCHAAF: You mean a higher premium rate with a rider.

DR. GARDNER: An optional premium rate in addition to the present rate which might cover just medical and surgical costs.

DR. SCHAAF: It covers all kinds of care. You get obstetrical care now and you get specialized care. Every type of care is included except some of the special services like radiology, pathology and physio-therapy. We even include anesthesia.

DR. GARDNER: I'm thinking primarily in terms of dividing into what might be considered general surgical and medical for one fee, and then an optional coverage for obstetrics or some of these other services which might come under an optional category.

DR. SCHAAF: We actually have that. If you have a husband-and-wife, for example, who are beyond the child-bearing period, their policy carries a lower premium rate than the obstetrical coverage, which is the highest family contract. There is quite a little difference. We have four gradations of premium rates now.

DR. LORRIMER B. ARMSTRONG (Union): I think it will be very wise to explain not only to the Delegates but also to the membership what the attitude of the Medical-Surgical Plan now is toward payment of assistant surgeons. There is still a lot of confusion in hospitals about that.

DR. SCHAAF: The confusion is thrice compounded since we met a year or so ago. It has nothing to do with the Medical-Surgical Plan.

In 1949, this Society urged the Medical-Surgical Plan to develop a method of payment for assistants. We agreed. It began in March 1950, actually, because Dr. Scott wrote the first letter about it to Dr. Hawley in 1950. Dr. Scott died immediately after, but correspondence with the American College of Surgeons continued.

After two years we finally got a statement from the College of Surgeons that the proposal we then offered was ethical and acceptable. Off the record, some of us were told orally that they hoped that the Blue Shield would adopt the proposal as a policy on a national level. But Blue Shield wouldn't do it; said it should be left to the individual state societies.

A proposed resolution was then circulated in county societies. One of the counties violently objected to it and actually introduced a

motion of censure to this body against the Medical-Surgical Plan for even mentioning or contemplating any such thing. The upshot of it was that that was referred for further study and a special committee was appointed on which there were representatives from every component county society. There was a circular questionnaire sent out to which we have the answers and the summary, and we were all prepared to come down here with something very wonderful when out came a promulgation from the College of Surgeons. I'll read it to you.

Those of you who are members of the College of Surgeons get the Bulletin each two months. This is published in the Bulletin of March-April 1954 and it appears on Page 72, and it shows where the Medical-Surgical Plan now stands and why.

"Because the proscription of a practice so often depends upon a precise definition, the Board of Regents, at their meeting on 7 December 1953, adopted the following definitions:

"1. An unjustified operation is one in which either the indications were inadequate, or the procedure was one which is contrary to generally accepted surgical practice.

"2. Ghost surgery is that surgery in which the patient is not informed of, or is misled as to, the identity of the operating surgeon.

"3. Fee-splitting is the refunding of any portion of the total fee for the care of a patient to either the surgeon or referring physician. Moreover, when the surgeon or the referring physician submits a joint bill, itemized or unitemized, it shall be interpreted as fee-splitting, according to the principles stated by the Judicial Council, and approved by the House of Delegates of the A.M.A., in December 1952.

"4. A fee is excessive when it is greater than the patient is reasonably able to pay or higher than justified by the service rendered.

"These definitions should end, within the American College of Surgeons, all debate upon what constitutes a breach of ethics in these four aspects of surgical practice. Their formulation was not accomplished without serious consideration of their impact upon wholly ethical requirements of surgical teaching and practice. The effect of the definition of ghost surgery upon resident training aroused the most concern; yet the Regents decided unanimously that honesty demanded that no exception be made in this respect. That good resident training can be provided within this limitation has been demonstrated.

"The definition of fee-splitting was changed to conform with the decision of the Judicial Council of the A.M.A., which was approved by the House of Delegates in their session in Denver in December 1952. Previous definition by the Regents had excepted a joint, itemized bill in which the amount of each charge was commensurate with the services rendered. This exception had been made primarily

to sanction the method of payment by insurance agencies, most of which demand a single statement and pay by one check.

"However, the A.M.A. makes no exception in such cases, and the American College of Surgeons both agrees with and intends to support the Code of Ethics of the American Medical Association. It is obvious that this decision of the A.M.A. makes unethical the methods of payment of most insurance agencies. Nevertheless it was the thinking of the Regents, and possibly that of the Judicial Council of the A.M.A. that the law should not be modified for the purpose of condoning violations. It is now distinctly up to insurance agencies to modify their practices so as to conform to the Code of Ethics of the American Medical Association."

So far as our Board is concerned, we cannot contemplate any division of fees as was projected a year or two ago. That is where we stand at this moment and it represents a complete reversal of the position of the American College of Surgeons under which we were proposing to operate up until this promulgation of March 1954.

DR. AARON H. HORLAND (Essex): Along the line of what you just read, Dr. Schaaf, how would you interpret a proper apportionment, if each part of the fee is made known to the subscriber? I can understand the A.M.A. saying that there shall not be a joint bill because that can be construed as fee-splitting. But how could you construe as fee-splitting a manner of payment which may have to take into consideration in the form of an indemnity to the subscriber.

We must accept one fundamental principle, as I see it. That is that a general practitioner who demonstrates ability to assist at an operation and does so and participates in the treatment of the case, is entitled to remuneration for his services. To say to him: You are eligible for payment from the patient directly, but the surgeon will get it from the Medical-Surgical Plan, is a discriminatory type of dealing; and certainly, while it doesn't condone it, masks fee-splitting.

In other words, if a general practitioner sends a case to a surgeon under a Medical-Surgical Plan basis, the surgeon feels in his heart and soul that that general practitioner who assisted and did worthwhile service should be paid and he knows there is no way that he can be paid except directly from the patient, and all of us sitting here know what a problem that will be. The surgeon, under cover, may give part of his fee to the general practitioner. That is what happens now, and I would not like to see that continue. Therefore, in our deliberations here this year I think we can evolve a plan that will in some measure be satisfactory to everyone.

I know that you can't please everyone and I was happy to hear Dr. Schaaf say that when we come down here we represent all the doctors in New Jersey. I don't subscribe to the thesis that you've got to have a certain ratio of specialists or this type of man or that type of man. We are mature men and we sit on a board of trustees. I have faith in the board of trustees because I know your position, Dr. Schaaf, and I know the position of the rest, and I know how you feel. So from that point of view I have no qualms.

But from *this* point of view I have plenty of qualms: you cannot raise rates arbitrarily because on an actuarial basis, as Dr. Borsner has informed me, that presents too much of a problem. For instance, if you have stated—I'm just stating this arbitrarily—we'll say, \$100 for an appendectomy, you can't just tomorrow or next year say it's going to be \$150 and \$50 of that is to go to the assistant. That is not the way of handling it; it isn't a practical way. But we may have to consider indemnity.

For instance, we may have to say to our subscribers: when you have a surgical case and your family doctor assists in it, you will be indemnified to the amount of \$100 for your operation. Now, the surgeon and your general practitioner who acts as his assistant will mail their separate bills. They may come to \$150; they may come to \$125; they may come to \$200; but each doctor who participates in that case will send in his bill and then the subscriber being indemnified a certain known amount and that's known to him when he takes the contract. I think that is an equitable basis.

The Medical-Surgical Plan is for all of us. Within the framework of such a wonderful type of insurance that we have developed we can solve this problem. To dismiss it simply because the A.M.A. appears to have thrown in a monkey wrench, I don't accept that.

The public must know what we are doing. We want to show them we don't want unnecessary surgery; we don't want ghost surgery; we don't want fee-splitting. But, for Heaven's sake, let us not adopt a program which will encourage it. Thank you. (Applause)

DR. SCHAAF: I always enjoy Dr. Horland because he hits the nail right on the head, and there is never any personal disagreement between him and me in these various arguments which we have from time to time.

The Medical-Surgical Plan does not make ethics, does not make patterns of practice. It tries to operate within the framework of the existing pattern of medical practice. Our Board went to great lengths over the years to develop what was finally approved by the College of Surgeons as an appropriate mechanism. We

are told now in unequivocal terms by the College of Surgeons that they have reversed their stand. What we proposed to do is no longer acceptable. We as an administrative board can't change that policy. They say it is unethical. We have to accept that.

Now, there is only one recourse in a situation like this. The same thing happened in New York last week. There were four principles enunciated by the State Medical Society in New York. One of them was: it shall not be unethical to apportion fees honestly between the attending surgeon and the physician. That was strictly counter to the A.M.A. thesis. They are going to take that resolution out to San Francisco and try to have it adopted as the national policy. But our Board can't do anything with that unless this Society says we will take the same stand as New York does and we will declare our own ethics.

Now, that isn't a practical thing to do, and one of the things that happened at the Trustees' meeting today in reference to the summary of the questionnaire which was sent out, that Dr. Armstrong headed up in Union County—that was sent to the Reference Committee with a cautionary note that it was of academic interest only unless it were preceded by the adoption of a resolution declaring it not to be unethical to divide fees. It is too complex. We have two bodies that worked on the College of Surgeons until they reversed themselves.

Now, who are we to take the position other than what they tell us is right unless this body, the House of Delegates, adopts a resolution which follows along with what New York State did.

We are all in sympathy with the plight of the practitioner who makes a diagnosis and participates in pre- and post-operative care and perhaps assists with the operation. We as a Board can't establish the mechanism unless it is acceptable, on an ethical basis, to the College of Surgeons and the American Medical Association.

DR. SACKS-WILNER (Mercer): I'm from the county that is violently opposed to the division of fees. There is a public relations problem here when we speak of the division of fees.

The *Philadelphia Inquirer* on May 13, as one of their leading editorials, spoke of this resolution in New York State. I would like to read you the three portions adopted by the New York State Society and what the *Philadelphia Inquirer* had to say about it. The headline is "Turning Back the Clock on Group Medical Care."

"Few, if any doctors today would propose going back to 19th century methods of medical care, 19th

century hospital facilities or 19th century operating techniques. Few would discard all the antibiotics and other drugs developed in the last hundred years.

"Yet the New York State Medical Society has taken a step which may result in turning back the clock on the economics of medical care. It has approved a program, to be put before the American Medical Association, which may destroy many health insurance programs not only in New York but in all of the U. S. A.

"The New York Medical Society has approved the following changes in the American Medical Association code of ethics:

"1. Advertising should be unethical if it was aimed at getting patients for a panel of physicians of a medical care plan, company or other organization.

"2. The practice of medicine by physicians on a salary should be restricted to institutions where patients are 'public charges'.

"3. Proration of fees is not unethical if both physicians or surgeons actively participate in providing medical care and if the fee is paid by an insurance company. (This legalizes fee-splitting.)

"There are other changes. But it will be seen that these alone would make the practice of group medicine difficult unless the U. S. court rules them monopolistic.

"Back in 1947 a group of prominent laymen joined in founding a health insurance plan for low-income families. Among those men were Winthrop W. Aldrich, Gerard Swope, Beardsley Ruml, the late Alfred E. Smith, and Wendell L. Wilkie. Today some 500,000 persons are medically insured under that plan. Similar plans in other cities are protecting thousands more.

"What makes the New York move of nationwide concern is the fact that it will have nationwide effect if approved by the A.M.A. Then it would hamper the work and expansion of all group medical organizations, even ban resident physicians in industrial plants.

"Above all, this New York scheme can be the most dangerous invitation to socialized medicine that the country has yet seen. Thanks to Blue Cross, Blue Shield and other forms of medical insurance and group protection, socialized medicine has had little appeal here compared with Great Britain.

"That's the way it should remain. And that's the way it will remain unless some of our medical politicians are grimly determined to keep medical care on a luxury basis for the vast middle-class of the U. S. A."

I'd like to answer, in rebuttal, one more thing that Dr. Horland mentioned. He implied that surgeons are splitting their fees with the general practitioner.

I'm from Mercer County. In our county I don't know of any doctor who is dividing, splitting, prorating or in any other term giving a part of his fee back to some referring physician. I do know that it is going on in North Jersey. I do know that it is going on in other states in the union. Some of these states are not even recognized by the American College

of Surgeons, or for entry of men of those states into the College of Surgeons. I know this has been going on for three years, and I have been on this stand once or twice in the last couple of years, and I know that on Tuesday we are going to have this battle all over again right here on the floor.

Thank you for your indulgence.

DR. SCHAAF: I hope Dr. Sacks-Wilner didn't think I was advocating adoption of such a resolution. I was explaining why the Medical-Surgical Plan could not adopt the system of proration of fees unless The Medical Society of New Jersey chose to follow the action of the New York State Medical Society, which in my opinion is not good public relations and not in the public interest. I was pointing out the difficulties under which our Board is laboring to bring about what so many people want.

A DELEGATE: May I ask the previous speaker how they pay the assistant in Mercer County?

DR. SCHAAF: I thought, myself, that El Dorado had arrived.

DR. SACKS-WILNER: This same question arose last year. About ten years or so ago I joined the staff of Wills Eye Hospital. My chief at that time, and still is, was Dr. James Shipman. I have never expected and we never expect a penny in return for my assistance in what I learned from Dr. Shipman and what I am still continuing to learn in the many years that I hope I will have in association with him.

I know that there is no man in Mercer County receiving money for assisting any physician. I think that what a man learns in the years that he assists is of far greater importance than the little bit of money that he might collect as an assistant and that might make him obligated to some particular man for an income.

There is a far greater danger in this splitting of fees than can be given in assigning money to an assistant. In certain parts of the state if a general practitioner refers a case to Dr. Jones he will get \$25, and if he refers it to Dr. Brown he will get \$40, and if he refers it to Dr. So-and-So he gets \$50, and so forth. You will make a bargaining process over the entire practice of medicine.

There is a story that goes around in New York City that there is no woman in the City of New York over the age of forty who has her ovaries, tubes, tonsils or appendix left. I said "story."

PRESIDENT DECKER: I'm going to refute what Dr. Sacks-Wilner said. I do not believe that fee-splitting goes on as he says it does, although I practice south of the Rancocas

River. I do not believe the story about the ovaries, tubes and the other things.

As you travel through the state and travel throughout the country, you will find that the men you meet are decent people practicing medicine. You will find no higher type of individual anywhere than the men engaged in the medical practice, and you will find that the ratio of rascals is much lower than in any other group. And I certainly deplore the fact that such statements are made without actual proof. (Applause)

DR. HORLAND: Members of the House of Delegates and Mr. Chairman: I certainly subscribe one hundred per cent to what Dr. Decker said. But, when a doctor approaches our rostrum and gives out information of the sort that you just heard, then we must think what the implications are. A simple question was asked from the floor: How do the assistants get paid in Mercer County? You heard the reply. I still don't know how they get paid except the implication, and that is that they are paid for being taught how to assist, in the sense that because they are assisting the surgeon, that is payment in itself.

Now, that is an idealistic way of doing things. We could say to the surgeon who is learning his surgery, because no matter how skilled a surgeon is, he is learning his surgery every day: Why pay the surgeon? Why not let the Government take over the whole practice of medicine and let the surgeon practice his surgery and learn from day to day and year to year on his patients without pay. To me that's the same kind of an argument to say that an assistant should be glad of the opportunity to assist.

Now, further than this there is another implication. We are now on a nationwide problem of how to integrate the general practitioner into this whole scheme of things. Should a general practitioner do surgery? What kind of surgery shall he do, and how will he be supervised? When a man or woman is graduated from medical school today, he takes a minimum of two years of a rotating internship. We have general practice residencies now throughout the country associated with university medical schools. So that when that general practitioner gets finished he has had enough experience to act as assistant in accordance with the plan that our doctor friend from Mercer County would establish. When that general practitioner is finished, he no longer qualifies to step into an operating room because, if we carry his argument to a logical conclusion, only those can train for surgery who are going to do surgery and nothing else. If that is our concept of medicine, according

to what this doctor said, then everything that the A.M.A. has said in the last convention and what Dr. McCormick is saying now is untrue.

Everyone seems to agree that general practice is the backbone of medicine, but when you come to put it into practice, he is that part of the backbone that fits in with the sacrum.

(Laughter)

I agree wholeheartedly with what Dr. Decker said. I have not in my experience as a physician, and I can say it looking everyone here straight in the face—I have not met a doctor in the associations that I have made in the twenty-seven years I have been in practice in Essex County, who I can honestly say, ever split a fee. I have heard talk about it, I've heard mention that it does happen, but I can assure you that it is very, very much in the minority. And I didn't want Essex County to go down with people thinking that in North Jersey we split fees. But in South Jersey the assistants are glad to work for nothing because they learn how to do surgery.

(Laughter)

I will finish by saying this, and this is in fairness to everybody: We are in medicine primarily because we like it. Who in the world would do what we do from early morning to late at night and then not only take the abuse from patients, although we do get nice things said about us from them, but the abuse from our own colleagues and still be satisfied with the income that we get compared with others who, with the same type of work, get much more, if it wasn't that we didn't like what we were doing. But we must have enough money to keep house, to bring up our kids and to have a car, and you can't do it by being taught for all of your medical career. There must come a time when you've got to get paid.

(Laughter and applause)

DR. LOUIS K. COLLINS (Gloucester): I also wonder how you pay the assistant. I work in a fifty-bed hospital in South Jersey below the Rancocas. We have no interns, no residents. We have four men doing major surgery, supervised by an FACS. He is the chief surgeon. I refer most of my surgery to him. I have only assisted him once and that was the night the hospital opened when we did a strangulated hernia and with very few instruments and resected part of the bowel. I billed the patient \$25; I think I got \$10.00.

Well, I send my patients to him, all major surgery, and he does the pre-operative and post-operative care, which I think he should and he should be paid for it. I don't want to be paid for it. But he gets an assistant from the hospital staff, who does not aspire to be a surgeon. He is not learning surgery. He is

working to make a living. He helps him on all his surgery. They did a hundred majors last month. I think he did fifty and I think the assistant helped in forty. Who is going to pay him? Me? The patient? The doctor? Who is paying him now? Why can't he be paid by a distribution of the medical-surgical fee? You know that the surgeon is paying him. He can't give him a stipend of so much a month. He may have 20 cases one month; he may have 50 the next month. He has to pay this man and he has to declare it in his income and he has to declare it as salary. And is he violating the code of ethics of the A.M.A. by doing that? Maybe there ought to be some way this man could be paid in assisting. After all, you don't want to let the surgeon do all the work, just have nurse assistants. That's not fair to the surgeon or the patient. If a man takes time out from his general practice, and that's all this other doctor is, a general practitioner—he happens to live in the town where the hospital is located and he helps with all the surgery that I send. Now, some of the other general practitioners assist in their cases, but I don't feel it is worth my time to do that. I have to conduct my own practice. Therefore, this man assists, and how are you going to pay him?

(Applause)

DR. SCHAAF: I will take just a moment to answer the doctor's question. The surgeon who has cases referred to him by this doctor and has some one else assisting in doing it, it is not fee-splitting if he pays him \$15, \$20 or \$25 for assisting. It is only called fee-splitting when the doctor sends a case, then assists, then gets \$15 or \$25. That is really the distinction.

I commonly have the same assistant who assists me with all my cases and I pay him so much for an assist. If he happens to send me a case, I bill my patient; he bills the patient for whatever service he renders. But any patient that he helps me with and happens to be my patient, I pay him and it is nobody's business because that is not fee-splitting. I could pay him the whole fee I got for assisting me, if I wanted to; it would not be fee-splitting because he didn't send me the case. That is the essential difference.

DR. DUFFY (Essex): I had the feeling, sitting and listening to all this, that this country has traveled so far down the road of the welfare state that we doctors feel people should be given things for nothing. Now, the Medical-Surgical fee for surgical procedures is the surgeon's fee for an operation. The assistant's fee was never included, was never expected to be part of the surgeon's fee.

The man who assists should be remunerated for his efforts. The assistant should be

paid through Medical-Surgical Plan. The Plan should give full coverage. Today there is no full coverage. The Medical-Surgical Plan does not consider the assistant's fee.

Now, they speak of the division of fees. Well, a few years ago Medical-Surgical was not supposedly a complete coverage plan. It paid so much toward surgical procedures. The patient was then expected to make an additional payment to the surgeon to cover the operation. That was a very unsatisfactory arrangement. The subscriber was unhappy about it. The plan was adopted whereby the fees were increased to make it appealing to the surgeon. They went along with the plan; accepted it as full payment. A year or two ago there was a general re-scaling of fees. I had the feeling that the fee schedule for certain procedures has been somewhat reduced. We can go a step further and reduce it again by including the assistant's fee in with the surgeon's fee. This can be done on paper, according to the rules. But I believe many men will drop out of the Medical-Surgical Plan. They will feel it is not giving an equitable return for their efforts.

Medical-Surgical fees should include the assistants. The assistants should be considered as part of the surgical procedure, should be covered by Medical-Surgical Plan. The subscriber should be made to appreciate that, just as he is to appreciate the surgeon's fee. Why divide a man's fee just to give some one something for nothing?

DR. SCHAAF: I'd like to point out to the doctor the Medical-Surgical Plan of New Jersey has never been on an indemnity basis except for people whose economic status was out of the covered category. Our original policy under which we operated in 1942 did not have an income limit but it had full coverage provided the subscriber did not take a private room. That policy also had coverage for payment of an assistant, but we had to abandon both of those items in the 1944 policy wherein we established a \$2,000 single person income limit. Under the 1942 policy, what happened? We had a different payment for the same service. You did an appendectomy for a hundred dollars, whatever the fee was at that time, and in certain cases we paid \$115 because they had a referring physician assist, and in other cases we did not pay the extra \$15. Well, now, what happened? That was very tempting. It wasn't long before the Plan found that paid assistants were being employed whenever the Medical-Surgical Plan case had coverage, whereas ordinarily that same surgeon used a houseman for the case. In other words, it became an im-

mediate imposition on the Plan. Many changes have been made to correct abuses.

For instance, consultations. We changed the system of reporting consultations, and what happened? In six months consultation fee demands jumped four hundred per cent.

Well, now, you can't operate a plan on things like that. On the assistant problem, we finally dropped the extra fee. It is still possible for the referring physician to send a legitimate bill and to collect it. We didn't make any pretense of covering everything. It doesn't exclude it. The difference is, if a surgeon's fee is paid, then the people don't think they need a second doctor. Now, that is a matter of education of the people if they want it. Frankly, the average surgeon needs no one but a qualified assistant whom he himself has trained or a houseman for most cases. He uses the referring physician as a courtesy. The referring physician, if he participates in the care of a case, should be adequately paid, but he should send his own bill and collect it. The argument is not that they can't send a bill, but they have very great difficulty collecting it.

DR. NATHAN S. DEUTSCH (Union): The personnel who have operated the Medical-Surgical Plan have done a splendid job. We lose sight of the fact that this is our own baby; that we set up this originally to take care of those who couldn't afford the higher costs of medical care. The Plan has done a splendid job. Surely there have been differences of opinion. That's what makes our Society go; in fact that's what makes horse races. I just want to get that set for the record.

I do want to bring up two points. Dr. SchAAF has answered one of them I was going to bring up; that is, our Medical-Surgical Plan was set up for a certain income group. It wasn't set up for the physicians on a specialist basis, not for the surgeons, obstetricians or anybody else.

I am a radiologist, and so is my colleague from Atlantic City. And as stated on the floor of this house last year, the radiologist was the forgotten man of medicine. I still say so. But Dr. Borsher has answered several of our questions very nicely, and when actuarially possible they will be taken care of to a certain extent.

What else has been done concerning the payment to non-participating physicians? We know that we have quite a number of non-participating physicians in our Medical-Surgical Plan. Certain recommendations were brought up at our last House of Delegates meeting. We hear a surgeon get up now, saying that if the fee in a surgical case is not increased, they will be non-participating physicians. Are we going to kill the golden goose

that has helped to save our lives, or are we just going to look out for our own economic side?

DR. BORSHER: The House of Delegates last year approved a proposal which originated with the participating physicians of the Plan. This provided that when a new service contract is issued by the Plan for services rendered by a non-participating physician, Plan payment will be made to the subscriber rather than to the non-participating physician. That will go into effect when a new service contract is issued. It cannot be applied under the current contract. It needs a new contract with a change in the wording of the contract than what it currently is, and it also needs approval by the Department of Banking and Insurance.

PRESIDENT DECKER: Gentlemen, this was scheduled to end at four-thirty; we are now twenty minutes past that. Are there any more questions?

My first contact with The Medical Society

of New Jersey, in the State office, was on the Hospital Relations Committee. The late Dr. Thomas Lewis was chairman. Dr. Sigurd Johnsen and Dr. Elton Lance were on the Committee. Dr. Elton Lance was detached to study a fee insurance plan that had been set up in New York City—that was about 1933 or 1934—and the work that he did with Dr. Lewis and later Dr. Scott and now Dr. Schaaf led to the development of the Medical-Surgical Plan of New Jersey, which is the oldest one in the country and which has been continuously successful. But the thing that you must always remember is that it is an insurance plan. Its operation is supervised by the Commissioner of Banking and Insurance and we can't, by wishing of the Trustees, change anything that is not set up in their schedule. It takes a long time to change these schedules.

If there are no more questions, I will entertain a motion for adjournment.

(Upon motion duly made and seconded, the House of Delegates was adjourned at 4:45 p.m.)

HOUSE OF DELEGATES

Session II

Monday Afternoon, May 17, 1954

The House of Delegates reconvened at 12:35 p.m., Dr. Henry B. Decker, President, presiding.

PRESIDENT DECKER: In the absence of Dr. Clark, Dr. Allman has a presentation that he would like to make to the House of Delegates and the Society.

DR. DAVID B. ALLMAN: Mr. President, Members of the House of Delegates: Through the State Chairman of the American Medical Education Foundation this award of merit comes to The Medical Society of New Jersey from the American Medical Education Foundation. It reads:

"For your outstanding contribution to the preservation and continuance of the high standards of medical education in the United States of America."

Affixed is the seal of the American Medical Education Foundation. The certificate is signed by Dr. Louis Bauer, President; George F. Lull, Vice-President; Edwin Turner, Secretary and Treasurer.

It gives me great pleasure, in the name of the American Medical Education Foundation, Mr. President, to present this to you and

through you to The Medical Society of New Jersey. (Applause)

PRESIDENT DECKER: Thank you. The Society will receive it, frame it, and cherish it.

The House of Delegates will be in order.

Mr. Secretary is there a quorum present?

SECRETARY GREIFINGER: Mr. President, there is a quorum present.

PRESIDENT DECKER: The business today is to receive the report of the Nominating Committee and act upon it. Dr. Harrold Murray, Chairman of the Nominating Committee, will present the report.

DR. HARROLD MURRAY: Mr. President, Members of the House of Delegates: I now present the report of the Nominating Committee, and move its acceptance.

(Dr. Murray then read the report of the Nominating Committee, attached here as Appendix 14.)

PRESIDENT DECKER: It has been moved and seconded that the report of Dr. Murray be received. Is there any discussion? Are you ready for the question? All those in favor signify by saying "Aye;" opposed, "No." So ordered.

Now we will act upon the nominations that have been presented by the Nominating Committee. Dr. Elton Lance automatically becomes President, so that we first vote on the President-Elect, Dr. Vincent P. Butler. Are there any nominations from the floor?

DR. JEROME G. KAUFMAN: Mr. President, I move you the nominations be closed.

(The motion was seconded.)

PRESIDENT DECKER: There is a motion that the nominations for President-Elect be closed. Are you ready for the question? All those in favor? Opposed? So ordered.

Now we will vote on Dr. Butler. Do I hear a motion that Dr. Butler be elected?

(The motion was duly made and seconded by several Delegates.)

PRESIDENT DECKER: It has been moved and seconded that Dr. Butler be elected President-Elect of The Medical Society of New Jersey. All those in favor? Opposed? We take it that the vote is unanimous. (Applause)

DR. MURRAY: Now, last year it was ruled that if there were no nominations from the floor, the Secretary, after a passed-motion, could cast a ballot. I will read the other names and ask for nominations from the floor for each position.

(Dr. Murray then read the names of the candidates. See Appendix 14. There were no nominations from the floor.)

DR. DECKER: May I ask if there are any nominations from the floor to fill these positions? If not, may I ask for a motion that the report be received and the Secretary cast a ballot?

DR. KAUFMAN: I so move, Mr. President.
(The motion was seconded.)

PRESIDENT DECKER: It has been moved and seconded that the report of the Nominating Committee be received and that the Secretary cast the Society's ballot for these candidates. All in favor? Opposed?

Dr. Murray, your report has been received and unanimously adopted.

I again request that you visit the exhibits, particularly the scientific exhibits in the Rutland Room. They are beyond the commercial exhibits so that you have to make a little effort to see them, but that little effort will be wonderfully repaid.

Reference Committee "C" will continue its meeting this afternoon at two o'clock on the 13th floor.

If there is no other business to come before the Society, I will receive a motion to adjourn until tomorrow morning at 9:30.

(The meeting was then adjourned at 12:50 p.m. on motion to that effect.)

HOUSE OF DELEGATES

Session III

Tuesday Morning, May 18, 1954

The House of Delegates reconvened at 9:40 a.m., President Decker presiding.

PRESIDENT DECKER: The House of Delegates will be in order.

Mr. Secretary, do we have a quorum?

SECRETARY GREIFINGER: Mr. President, we do have a quorum.

PRESIDENT DECKER: We will proceed with the regular order of business. Reference Committee "A" will report. Dr. Kump is Chairman.

(Dr. Kump then read the report of Reference Committee "A." See Appendix A. This was accepted, section by section, upon motions regularly made, seconded and carried.)

PRESIDENT DECKER: Dr. Carl Ware, you have a duty to perform. Will you bring Dr.

Hewitt Smith forward? Dr. Hewitt W. Smith is President of the Medical Society of Delaware. We have looked for him for two days and finally found him late last night. He told us he had been here all the time, but had become so involved in looking at the exhibits that we couldn't find him.

DR. HEWITT W. SMITH: Dr. Decker, Members of the House of Delegates: I am not a long-winded politician, neither am I a member of the Senate Sub-Committee investigating Communist infiltration into the Armed Forces. I'm merely a practitioner of medicine, general practitioner at that (Applause), and for that reason a member of the American Academy of General Practice.

I wish to bring greetings from the Medical Society of Delaware to the venerable Society

of New Jersey on this, their 188th Annual session.

The Medical Society of Delaware will hold its annual meeting in Dover, Delaware next October. That will be our 165th annual session. I would consider it a privilege indeed to greet each and every one of you personally if you can get away from your active practices and come down and visit us in Dover, Delaware.

The problems that we face in Delaware are similar to those that you face in New Jersey. Right now we are confronted with the problem of revising the code of Delaware relating to the practice of medicine, which has been in effect for thirty years. We have the problem of hospitals not accredited by the American Medical Association which have turned to the services of doctors who are neither American citizens nor graduates of approved medical schools. It is indeed a problem and one which I think you face here in New Jersey. Delaware, like New Jersey, has no medical school. That problem will have to be faced and faced quickly.

We have the problem also of the emergency medical call service in rural areas, which we are trying to conquer. We have the problem of public relations. We have no organized public relations department. Each man is his own public relations department, spreading good public relations not only among the public and patients but among physicians themselves.

I congratulate The Medical Society of New Jersey for the program that they are putting on here this year. I attended the sessions in this room yesterday. I wish to compliment them on the quality of the work of their staffs; it is of high order. The technical exhibits are well chosen. The scientific exhibits, too, are outstanding. I want to spend more time with them today and tomorrow.

Dr. Decker asked me to tell you something about Dr. Fooks. That's a pretty touchy subject because Dr. Fooks was a student under Dr. Decker quite a few years ago. Dr. Fooks has some very fond recollections of one occasion that happened during his training. Dr. Fooks was a first year medical student and Dr. Decker wrote down on a piece of paper and said: "Now, you take this paper over to Dr. Rosenberger and tell him I want some of it." Dr. Decker wrote down the word "meconium." And so Dr. Fooks, a fledgling with no experience, went over to Dr. Rosenberger and said: "Dr. Decker sent me over here. I want some of this meconium." Dr. Fooks was innocent; he didn't know what meconium meant. I'll not repeat the words Dr. Rosenberger used, but he said: "It's baby's." You know the rest.

He added: "I haven't got any of it, but you go back and tell Dr. Decker that he is full of it." (Laughter) So that was the story on that. There are some other anecdotes, too, that I am not going to bring up. I don't want to embarrass Dr. Decker.

In conclusion, I sincerely thank every member of The Medical Society of New Jersey, on behalf of Mrs. Smith and myself, for the very fine, kind and generous efforts in asking us to attend this annual session. It has indeed been a very profitable one for me. Mrs. Smith is enjoying herself with the Woman's Auxiliary, and I'm sure that both of us will carry with us, when we leave here, many, many pleasant memories which we will recall often in the time to come. Thank you, folks.

(Applause)

PRESIDENT DECKER: Thank you, Dr. Smith.

That story that he told has a small grain of truth in it. (Laughter) But, as with many of those stories, they have enlarged during the years.

To proceed with the next order of business, we will have the report of Reference Committee "B." Dr. Marcus Greifinger.

(Dr. Greifinger then read the report of Reference Committee "B," which is printed in Appendix B here. This upon motion regularly made, seconded and carried was adopted.)

PRESIDENT DECKER: Dr. Gardner, will you give the report of Reference Committee "C"? If you need us to support your arms, we'll be on either side.

(Dr. Gardner then read the first two pages of the Report of Reference Committee "C." See Appendix C-1. These were accepted, section by section, upon motions regularly made, seconded and carried. Dr. Gardner then read page 3 of the report, as follows:)

DR. GARDNER: "The committee reviewed at great length the resolutions offered by the Mercer County Medical Society and the Hudson County Medical Society on the division of surgical fees by Medical-Surgical Plan. The committee did not approve the resolutions as presented, but used them as the basis for discussion and recommendations of the committee which appear later in the report."

I would like to comment briefly on each of the following recommendations which this committee will offer. The hope is to provide a solution to the impasse about the payment of fees to one or more physicians who actively participate in the same procedure.

"Following a lengthy period of discussion

of the problem of division of fees by Medical-Surgical Plan, the committee makes the following recommendations:

"1. Any physician who assists in a medical, surgical, or obstetrical procedure is entitled to receive a fee commensurate with the services he renders."

During our committee hearing it was apparent that most physicians who attended the hearings were in agreement that this was desirable. Nothing is ever unanimous, but on this particular portion, we felt the majority of the members agreed.

"2. The determination of eligibility of an assistant in a medical, surgical, or obstetrical procedure shall be the direct responsibility of the hospital service concerned."

You gentlemen who attended the hearings know that there was considerable difference of opinion as to what constituted eligibility. Eligibility varies from one section of the state to another, from one county to another, from one hospital to another. It was felt that it should be decided as a local matter within each hospital and that the hospital staff should assume that responsibility for determining which physicians on their staff were eligible to become assistants. However, a minority report will be presented on this part of the report.

Number 3, as recommended by the majority of the committee is as follows:

"It is the opinion of the committee that the fee as listed by Medical-Surgical Plan for a surgical procedure is an all-inclusive fee. It does not represent the fee for the operative procedure alone. Therefore, the committee recommends that the total fee for the procedure be reapportioned, and that a new schedule of fees be established to provide payment for adequate and active pre-operative and post-operative care and for technical assistance at the operative procedure itself as well as for the operative procedure."

We felt that this procedure as we recommended must work within the present financial structure of the Medical-Surgical Plan. Whatever amount is available must be used to make these subdivisions. If the fee allowed by the Plan means total fee for all services rendered for each procedure, then a definite fee to be specified by the Medical-Surgical Plan for each portion of the service will provide a uniform division of fees. This would permit any participating physician to bill the Plan for the portion of the service he rendered.

"Number 4: Each physician who participates actively in the cure of a patient shall send his bill for

services separately to the Medical-Surgical Plan for payment."

We felt that, as far as the Medical-Surgical Plan is concerned, we ought to eliminate the problem of fee-splitting. There can be no question of fee-splitting when the fee for each service or portion of service is specified by the Plan and each participating physician bills the Plan directly for his individual services.

Mr. Chairman, this is the report on this portion by this committee. Dr. Corio's name is left from the bottom of this report, but he was a participant in this.

I move the adoption of this portion of the report.

(The motion was seconded.)

PRESIDENT DECKER: Is there a minority report? The Chair is awaiting such a report. We invite you, Dr. Corio.

DR. CORIO: Thank you very much.

Mr. President, the undersigned, a minority on Reference Committee "C" appointed by the President, not agreeing with the majority, desires to express his views on the matter.

(Dr. Corio read his minority report, Appendix C-2.)

DR. MORICONI: I move the substitution of the minority report for the original report.

DR. R. JOHN COTTONE (Mercer): I second it.

PRESIDENT DECKER: It has been moved that the minority report be substituted for the report of the committee.

The discussion is now on the minority report, which will be what we will vote on when the question is put.

A DELEGATE: Point of order. You have a motion for the adoption of the majority report. It is being discussed now.

PRESIDENT DECKER: We will recess while the Parliamentary suffers.

The Chair rules, after consultation with the parliamentary brains of our organization, that the motion to substitute will now be put to the question. The motion is to substitute the report of the minority of the Committee for the majority report. It has been seconded. Are you ready for the question?

DR. MORICONI: Mr. Chairman, I would like to discuss the minority report.

PRESIDENT DECKER: This motion of substitution is not debatable. The question will be put. It is not out of order.

DR. MORICONI: Mr. Chairman, Robert's *Rules of Order*—

PRESIDENT DECKER: You are ruled out of

order. We have Robert's *Rules* here. We are voting now on whether we substitute the minority report for the majority report. There will be plenty of time for discussion later of all these things.

Are you ready for the question?

DR. MORICONI: How can we be ready? We can't discuss it.

PRESIDENT DECKER: Are you ready for the question? All those in favor of substituting the minority report for the majority report will give the sign. Opposed? The Noes have it. Now we will proceed with the regular order of business and discuss the report.

DR. YAGUDA: Mr. Chairman, a point of order. Does that mean that the minority report is not to be discussed at all?

PRESIDENT DECKER: The minority report is not to be substituted for the majority report. We are now discussing the report of the committee. Whether you will accept or reject that report is within the province of the House of Delegates.

DR. MORICONI: Mr. Chairman, I would like to voice an objection. I originally stated that the minority report—I made a motion on the minority report as an amendment to the majority report and you refused it. Then you asked me if it would be a substitution report and I said yes. Now, either one way or the other we should be permitted to discuss a portion of the minority report.

PRESIDENT DECKER: You can discuss it now in great length and great detail and with great fervor, if you will sit down and proceed in the regular order of business.

DR. SCHAAF: Mr. Chairman, I move an amendment to the paragraph at the bottom of Page 2, which reads: "The committee considered the report by the Special Committee on the Problem of Division of Fees under Medical-Surgical Plan, as submitted by Dr. John E. Leach, Chairman;" and substitute for the phrase the "problem of division of fees under Medical-Surgical Plan," the phrase: "apportionment of available surgical benefits."

(The motion was seconded.)

PRESIDENT DECKER: Are you ready for the question? Is there any discussion on this amendment before we vote? Are you ready for the question on Dr. Schaaf's amendment?

DR. CORIO: Mr. President, will you state the question again?

DR. SCHAAF: I move that the phrase "the problem of division of fees under Medical-Surgical Plan" be changed to read: "The problem of the apportionment of available surgical benefits by Medical-Surgical Plan."

PRESIDENT DECKER: It is a change in wording.

DR. SCHAAF: The way it is written now there is a connotation of fee-splitting in it, and I strongly object to that connotation.

PRESIDENT DECKER: Are you ready for the question? All those in favor of this amendment will say 'Aye.' Opposed? Carried.

DR. SCHAAF: Mr. Chairman, I offer an amendment reading similarly in the first paragraph of Page 3 where I would prefer to see the words "apportionment of available surgical benefits" substituted for "division of surgical fees by Medical-Surgical Plan."

(The motion was seconded.)

PRESIDENT DECKER: It has been moved and seconded that the wording of that paragraph be changed as Dr. Schaaf indicated. Are you ready for the question? All those in favor give the usual sign. Opposed? So ordered.

DR. SCHAAF: Before going on with the other points, I would like to indicate to the House of Delegates that whatever requests or advice they wish to transmit to the Board of Medical-Surgical Plan are always gratefully received and acted upon when possible; however, this body has no legal authority to issue edicts to the Board of Medical-Surgical Plan, which is a separate corporate body responsible to the Department of Banking and Insurance.

Therefore, I would like to amend Paragraph One to read: That the Medical-Surgical Plan be requested to consider the practicability of separate payment for surgical assistants. Paragraph 1: "Any physician who assists in a medical, surgical, or obstetrical procedure is entitled to receive a fee commensurate with the services he renders."

The Plan has been through this problem of payment of assistants. We had to abandon it after two years of very troublesome and unhappy experience with it. I don't want to go into the details of it, but it is something that caused us no end of trouble and we abandoned it when we wrote our second policy. So that the Medical-Surgical Plan is requested to, and then so on.

I'd like to offer that as an amendment. I move that the Board of the Medical-Surgical Plan be requested to study the practicability and advisability of payment for surgical assistants in a surgical or obstetrical case. That's the issue. We have no medical assistants as such; we have consultations. We are talking about operations on the table.

"Any physician who assists in a medical, surgical, or obstetrical procedure is entitled to receive a fee commensurate with the services

he renders." What you want on that is to ask the Board to consider the possibility of payment.

PRESIDENT DECKER: Dr. Schaaf, I disagree with that.

DR. SCHAAF: Then I'm asking that that be substituted for Number 1; that you ask us to study the feasibility of putting it. This is a substitute.

PRESIDENT DECKER: Is there a second to this amendment?

(The motion was seconded.)

PRESIDENT DECKER: This is now open for discussion.

DR. HORLAND: Mr. Chairman, I rise to a point of order first.

PRESIDENT DECKER: All right, Senator. (Laughter)

DR. HORLAND: Thank you for the compliment.

Members of the House of Delegates, and my distinguished friend, Dr. Decker, whom I love very much. I mean that, because he is our friend. Let me tell you something, gentlemen. I'm not going to be formal today. I want you all to sit back and relax because this is a question of parliamentary procedure.

The report has been brought in by the majority, and Number 1 states very plainly: "Any physician who assists in a medical, surgical, or obstetrical procedure is entitled to receive a fee commensurate with the services he renders." There is nothing in here that's a directive. There is nothing in here that says the Medical-Surgical Plan must do it. It's simply an expression of our will and desire and of our policy as adopted by the House of Delegates if we adopt it.

Now, if Dr. Royal Schaaf, whom I also love very much and whom I fought with on many things, and he knows how I feel—I think that Dr. Schaaf, sorry as I have to say this, is out of order in recommending an amendment at this time to this.

He got up to discuss this report. Now, if he wants to present an amendment, that's another story; and if he wants to lead me to believe that this is a directive to the Medical-Surgical Plan, I disagree with him. We, as a House of Delegates, and I repeat for emphasis, we have a right to establish a policy. This is our policy. The Medical-Surgical Plan has the right to implement it or not, as they see fit; and if they do not implement it, we have the right to elect a new Board of Trustees; not that I am insinuating that that should be done, because I'm the last one to adopt the procedure that Mercer County has adopted, of

withdrawing from the Plan. I think that part in their original resolution condemns that type of thinking.

Dr. Murray and Dr. Schaaf and Mr. Bryan know how much we all went up and down the state fighting socialized medicine, and we'll have that fight all over again if we cannot unite on a simple problem like the payment for medical services and the distribution of medical services. It's a wonderful thing that our Medical Service Administration has handed this thing to Congress to consider as a substitute for that re-insurance plan.

I'm appealing, Number 1, for unity in this house; Number 2, not to confuse the issues; and Number 3, that this resolution as presented by the majority report is an excellent resolution, fair and just in every way and is in no way construed as dictating to the Medical-Surgical Plan Board of Trustees. It is the establishment of our policy, gentlemen. I consider it as such. (Applause)

DR. SCHAAF: What I'd like to know, Mr. Chairman, is: Are we discussing a report of the Medical-Surgical Plan and are we being given advice by the House of Delegates, or is this a totally separate and distinct enunciation of principles and policies by the House?

Now, if it is the latter, I am out of order. But if it is the former, it is in order, and I have been going under the impression I was talking about advice and guidance being offered to the Medical-Surgical Plan. After all, I sat through this Reference Committee yesterday a good many hours. I came away with the definite impression that the Reference Committee was going to ask us to do certain things.

PRESIDENT DECKER: Dr. Schaaf, I feel that Paragraph 1, which you specified, is a statement of principles; that the laborer is worthy of his hire. I see no directive in that to the Medical-Surgical Plan or anyone else. I think that your amendment has to do with Paragraph 3 of this.

DR. SCHAAF: Mr. Chairman, I hate to differ. It says: "The committee makes the following recommendations." It's not a declaration of principles; it is a recommendation. Now, who is the recommendation to? It must be to the Medical-Surgical Plan. That's what it says.

PRESIDENT DECKER: These recommendations are to the House of Delegates, Dr. Schaaf, which we are now considering.

DR. SCHAAF: Where are they going? To the Medical-Surgical Plan?

PRESIDENT DECKER: We have to act on them first. We are presently discussing them.

Now, the question before the House is the amendment which Dr. Schaaf submitted to Paragraph 1. Do you have the exact wording?

MR. NEVIN: I have it here, Doctor. That the Board of the Medical-Surgical Plan be requested to study the practicability and advisability of paying any physician who assists in a surgical or obstetrical procedure, a fee commensurate with the services he renders.

PRESIDENT DECKER: Now we are voting on this amendment. Are you ready for the question?

A DELEGATE: Mr. Chairman, could I make this suggestion: Instead of a fee, the word be: is entitled to receive compensation commensurate with the services rendered. Now, I say that because some assistants are not paid; they are training, and the minute you put a fee in there then it begins to—now, wait a minute. This is no monkey business. Some assistants are not paid; they are trained, and therefore they may not want to be paid.

PRESIDENT DECKER: We are voting on the amendment. Are you ready for the question? If you support the amendment, it changes the first paragraph. If you reject the amendment, the paragraph remains the same.

DR. HORLAND: Point of order, Mr. Chairman.

PRESIDENT DECKER: All right, Senator.

DR. HORLAND: I again respectfully and humbly arise to protest that type of language because we as a House of Delegates have a right to promulgate policy. God knows that the Medical-Surgical Plan has studied and re-studied and found out the practicability or not of having surgical fees for the last four years. Why delay and do some more studying? I'm absolutely and totally against such language because it implies that it needs to do more studying. All our work and all our discussions here count for naught if you vote for this amendment, and the amendment is out of order. (Applause)

PRESIDENT DECKER: All right; the question is on the amendment. Are you ready for the question? All those in favor give the usual sign. All those opposed? The amendment is rejected.

DR. SCHAAF: I would like to point out for the Medical-Surgical Plan that the determination of eligibility of an assistant is of no legal importance. The eligibility is already determined by the Board of Medical Examiners when it grants the license. Legally we cannot undertake to pay or not pay an assistant or a consultant on somebody else's qualifications.

Now, if this is not instructional or a recommendation to the Medical-Surgical Plan, I will offer no comment. If it is to be intended as an instruction or request to the Medical-Surgical Plan, then I move that that paragraph be deleted.

A DELEGATE: The issue before the House is becoming beclouded. We are discussing resolutions presented by the Mercer County and Hudson County Societies. The committee rejected those resolutions and replaced them with one of its own. This is not discussing any report of the Medical-Surgical Plan. This merely states what the committee feels this House should adopt. It casts no reflection upon the report of the Medical-Surgical Plan or upon its activities and certainly doesn't try to impress anything upon them. I imagine it would be proper to send a copy of this resolution to the Medical-Surgical Plan, but certainly this is in no way that I can see critical of it or of their report.

DR. SCHAAF: Mr. President, I submit that if this is included in the Medical-Surgical Plan report it is proper to discuss it at this time. After all, the whole thing emanates from the report of the Medical-Surgical Plan. Certainly it can't be out of order to discuss it now. If it is a report on a resolution to the Medical-Surgical Plan, it should have gone to another committee.

PRESIDENT DECKER: Dr. Schaaf, we are not going to limit discussion, but we are going to try to limit it to proper discussion. The amendment you offered applies to Paragraph 3.

DR. SCHAAF: I passed that. I offered to delete Paragraph 2.

PRESIDENT DECKER: The determination of eligibility of an assistant is not within the province of any insurance company. It is within the province of a hospital or a physician. We are restating that principle as we restated the first principle.

Now, the third paragraph has to do with the fee schedule with which the Medical-Surgical Plan is interested. It is a suggested change to eliminate much of the difficulty that has gone on, and if you will make your amendment now the Chair will be very glad to accept it for discussion.

DR. SCHAAF: I moved to amend Number 1.

DR. MORICONI: Mr. Chairman, is the discussion still open on Paragraph 2?

PRESIDENT DECKER: There was never any discussion on Paragraph 2. The motion was not seconded. We now go to Paragraph 3.

A DELEGATE: For purposes of discussion, I will second it.

DR. MORICONI: Mr. Chairman, we are discussing Paragraphs 1, 2, 3, and 4 of the recommendations. Why can't we come up and talk about Paragraph 2? If you let Dr. Schaaf talk about it, why can't somebody else talk about it? The motion has been made and seconded to accept the recommendations by the ma-

jority of Committee "C." We can talk on any paragraph we please.

PRESIDENT DECKER: The gentleman is perfectly right.

DR. MORICONI: The minority recommendations of Reference Committee "C" included following, made by Dr. Corio: "I agree with recommendation Number 2 with this addition: that the eligibility conform in accordance with the recommendations of the Joint Committee on Accreditation of Hospitals. Personnel of each service shall be qualified by training and demonstrated competence and shall be granted privileges commensurate with their individual ability."

Now, the hidden sore in that particular amendment which I am offering is this: I listened to an awful lot of talking yesterday; did a little bit myself. Basically and fundamentally we are trying to prevent subterfuge. We in Mercer County believe that a doctor should be paid for his work. I think everybody knows that, but we think that there are certain principles that we should abide by and one of these principles is that the man who receives payment should be worthy of his hire. We believe that the American College of Surgeons, the A.M.A., the Joint Committee on Accreditation of Hospitals and the American College of Physicians, so forth and so forth, aren't wasting their time when they desire that hospital staffs be made up of men who have proved themselves and the quality of their surgery and their medicine to improve the general health of the community. And that is the reason why they propound proposals of this kind.

I want this amendment passed, if possible to prevent the helter-skelter assistanceship by men who are not well qualified to assist. I don't think doctors who are doing serious surgical or contemplating an intricate obstetrical maneuver would like to pick up somebody from the street to give them a hand. I think he would rather have somebody who knows a little about the subject—qualified assistanceship. And if that man is qualified through the action of the board of the hospital, the action of which is guided to a great extent by the Joint Committee on Accreditation of Hospitals, I believe that the patient's welfare would be better safeguarded.

I therefore move that the amendment as read here, "That eligibility be in accordance with the recommendations of the Joint Committee on Accreditation of Hospitals; personnel of each service shall be qualified by training and demonstrated competence and shall be granted privileges commensurate with their individual ability," be added to Recommendation

2, Page 3 of Reference Committee "C" 's report.

DR. YAGUDA: I second it.

PRESIDENT DECKER: You have heard the amendment. It has been seconded. Is there any discussion on the amendment?

DR. HORLAND: I agree wholeheartedly, and I know we all do. The point that Dr. Moriconi has made is an excellent one and I approve it one hundred per cent, and we all should. What he says there is exactly what we are fighting for. His words are better than the ones that are in the original resolution presented by the majority report. That is exactly what we want. No one should assist at an operation unless he is properly qualified. And the Joint Commission of Accreditation does set it up. I know it; I studied it; worked hard on it for hours and hours out in Cleveland. This doesn't jeopardize or discriminate against anyone. It is a good amendment and should be accepted. But that is not the issue.

PRESIDENT DECKER: Is there any further discussion on the amendment? The Chair is going to rule that it must add something to the thing or the discussion will be ruled out.

DR. WINTON H. JOHNSON (Bergen): Again it seems that in this majority report the committee and those who were discussing it wish to set a policy of this House of Delegates to be used if they wished; that is, the Medical-Surgical Plan if they wished to follow out Paragraph Number 3. As I understood it, it was not a directive that the Medical-Surgical Plan had to follow. It was simply an expression of the majority feeling of this House of Delegates if it is passed as it is.

Regarding the amendment that was just proposed, it says exactly the same thing as the majority report.

And in answer to the doctor's fear that a surgeon could take somebody off the street to assist—it seems rather ridiculous that a doctor who goes through four years of medical school, internship training, does many of these procedures as an intern and resident and comparing him with a person taken off the street seems rather far-fetched and again trying to confuse the issue. (Applause)

DR. GARDNER: I'd just like to clarify one point. The committee discussed Dr. Moriconi's recommendation and we tried to say the same thing, I think, in only a little different way. We felt that the hospital staff could make its own decision. We depend on the integrity of the staff to determine which doctor is eligible. We didn't feel we should spell out how it should be done. It is the right and responsibility of

each hospital staff to determine who is the eligible assistant in their department.
(Applause)

PRESIDENT DECKER: Are you ready for the question on the amendment that Dr. Moriconi read to be substituted for Paragraph 2?

DR. MORICONI: Added to.

PRESIDENT DECKER: Added to Paragraph 2. Are you ready for the question? All those in favor? All those opposed? The Noes have it. The amendment has been lost.

DR. MORICONI: Mr. Chairman, may I speak on Paragraph 3?

PRESIDENT DECKER: Yes.

DR. MORICONI: I would like to amend Paragraph 3 of the majority recommendations of Reference Committee "C," to read as follows:

"That the fee made payable to the assistant be in addition to that already allocated to a medical, surgical, or obstetrical procedure, and to include pre- and post-medical, surgical, or obstetrical care."

It has been alleged that we of Mercer County are trying to reform The Medical Society of New Jersey. Far be it from us to try to reform anybody. We are only attempting to show as clearly as possible that the changes proposed by the majority here are fraught with dangers. Paragraph 3 is fee-splitting whether you call it reallocation or reapportionment of funds. It is a "division of funds" or "fees" or "compensation," call it what you will, for the payment of fees for services rendered.

For example, a fee, let us say, of \$150 can be called an allocation, an apportionment, proper compensation, anything you want to call it. Let us say that \$150 is set aside for a surgical procedure. Now, if a surgeon has no assistants and does the operation by himself, he automatically collects the \$150. If he is fortunate enough to obtain the able assistance of the referring doctor, the fee, by the process of linguistic legerdemain, becomes reallocable and he gets \$125; that is, \$150 minus the \$25 that is paid the assistant. Now, that is "division of fees." Or are we just "reallocating funds"? Whom are they kidding? In how many ways can you twist English for your own purposes?

The precedent here is transferable to non-insurance cases which form 75 per cent of the medical contacts of the people in New Jersey. If, in the Plan, we start dividing fees—and I like that term because it is perfectly open and shut and it means just what it says—we will have to do the same thing for patients not covered by the Medical-Surgical Plan. It therefore becomes a known policy throughout the country that The Medical Society of New

Jersey has gone on record as favoring a "division of fees." Some states call it fee-splitting. We now call it "reallocation" or "reapportionment." It's the same thing, no matter which way you look at it.

Now, I want to read something which came to my attention sometime ago. This comes from the March, 1954 *Bulletin of the American College of Surgeons*. The caption is: "Regents Define Unethical Practices." Here is the text:

"Because the proscription of a practice so often depends upon a precise definition, the Board of Regents, at their meeting on 7 December 1953, adopted the following definitions:

"1. An unjustified operation is one in which either the indications were inadequate, or the procedure was one which is contrary to generally accepted surgical practice.

"2. Ghost surgery is that surgery in which the patient is not informed of, or is misled as to, the identity of the operating surgeon.

"3. Fee-splitting is the refunding of any portion of the total fee for the care of a patient to either the surgeon or referring physician."

Gentlemen, that fund can be called a "fee"; can be called "compensation"; can be called an "apportionment"; can be called an "allocated fund." It's the same.

"Moreover, when the surgeon or the referring physician submits a joint bill, itemized or unitemized, it shall be interpreted as fee-splitting, according to the principles stated by the Judicial Council, and approved by the House of Delegates of the A.M.A., in December 1952.

"4. A fee is excessive when it is greater than the patient is reasonably able to pay or higher than justified by the service rendered.

"These definitions should end, within the American College of Surgeons, all debate upon what constitutes a breach of ethics in these four aspects of surgical practice."

Now, gentlemen, these principles were adopted not only by the American College of Surgeons but by another society, the American Medical Association. Here it is.

"Their formulation was not accomplished without serious consideration of their impact upon wholly ethical requirements of surgical teaching and practice. The effect of the definition of ghost surgery upon resident training aroused the most concern; yet the Regents decided unanimously that honesty demanded that no exception be made in this respect. That good resident training can be provided within this limitation has been demonstrated.

"The definition of fee-splitting was changed to conform with the decision of the Judicial Council of the A.M.A., which was approved by the House of Delegates in their session in Denver in December 1952. Previous definition by the Regents had

excepted a joint, itemized bill in which the amount of each charge was commensurate with the services rendered. This exception had been made primarily to sanction the method of payment by insurance agencies—"gentlemen, I want to repeat that. "This exception had been made primarily to sanction the method of payment by insurance agencies, most of which demand a single statement and pay by one check." The Medical-Surgical Plan is an insurance agency, as Dr. Schaaf very clearly stated today.

"However, the A.M.A. makes no exception in such cases, and the American College of Surgeons agrees with and intends to support the Code of Ethics of the American Medical Association. It is obvious that this decision of the A.M.A. makes unethical the methods of payment of most insurance agencies. Nevertheless it was the thinking of the Regents, and possibly that of the Judicial Council of the A.M.A., that the law should not be modified for the purpose of condoning violations." I don't think we can be much clearer than that. That's pure King's English. "It is now distinctly up to insurance agencies to modify their practices so as to conform to the Code of Ethics of the American Medical Association."

Gentlemen, I move that Paragraph 3 be amended to read: "We recommend that the fee made payable to the assistant be in addition to that already allocated to a medical, surgical, or obstetrical procedure, and to include pre- and post-medical, surgical, or obstetrical care."

(The motion was seconded.)

PRESIDENT DECKER: The amendment has been received and seconded.

DR. JOHNSON: Gentlemen, you certainly have heard a beautiful confusion of the facts. No one here in the House of Delegates, and no one on the Reference Committee, in any way sanctions unnecessary surgery, and if these surgeons are such respectable and reputable persons, I cannot understand how an assistant off the sidewalk can do the unnecessary surgery. On the question of ghost surgery, we are all agreed. Those who do not participate are not entitled to any portion of a surgical benefit.

We are offering a recommendation to the Medical-Surgical Plan that the doctors who render a service should be paid. This question of refunding and referring to these recommendations by the ethics committee and so on—if you listen to the words you can see the complete difference of the plan we propose as to what was said there. Refunding means giving back. The Medical-Surgical Plan is not being requested to give one check to the surgeon or to the assistant and have him slip something to the other doctor. That is unethical. We are all agreed, and we don't want that type of practice. We are now asking the Medical-Surgical

Plan (and Dr. Schaaf has agreed with us) that the bill be rendered separately and that the Plan pay for services rendered by the doctors in the particular procedure.

The other misrepresentation is that many have assumed that that benefit which the Plan allows is the surgeon's fee. I have never seen that stated in any of the contracts of the Medical-Surgical Plan. It merely states that this is the amount for the premium paid that we will allow you on a particular procedure. The Plan does not specifically say that the surgeon is the only one who will be paid; that the others who do it, do it for instruction. They say it is perfectly all right to go ahead and send your own bill and collect, if you can, from the people.

The doctor also intimated that 75 to 80 per cent of the people of New Jersey are in the group that we are speaking about. If he corrected his figures, he would say 75 to 80 per cent of those participating in the Plan are covered by this; and there are a good many that are not; and some of those that are not certainly are in a position different from those covered in that percentage of those with the Plan.

The amendment they are proposing is in direct conflict with the very canon of ethics that he was talking about. In one sentence he objects to division of fees, even if we call it payment for services rendered. That seems to be his idea of a division of fee. Then he turns around and offers a resolution that says it is perfectly all right for the Plan to pay the assistant something else if they do it, in addition to that which they already allowed. Well, the Plan is a business organization. They can pay only in proportion to the premiums received. What difference does it make if the operation is, at the present time, allowed \$100? If they now allow \$125 and pay the \$25 for the assistant and \$100 to the surgeon, then the whole argument is whether the surgeon is willing to accept a little less of that benefit which is at present allowed and give the remainder to the other man who is working as hard and as interestedly on the people. (Applause)

The other question is the concern which Mercer County has for the welfare of the people of this country. One of their learned colleagues got up the other day and said: we take care of the general practitioner in Mercer County by sending the patient back to him after the operation in order to get some liver injections for the next six weeks. Now, if that is a specimen of concern for the welfare of the general public by the Mercer County group, I think the northern county members can teach

them something about good medical practice. (Applause)

PRESIDENT DECKER: Gentlemen, we are all practicing medicine throughout the state. I do not like the references to this group who are not thus and that and so forth and so on. Let us exclude those things from our discussion.

We are now discussing the amendment that Dr. Moriconi submitted to Paragraph 3.

DR. DUFFY (Essex): Mr. President, Members of the House of Delegates: Dr. Johnson's confusion is readily understandable when one appreciates that he considers the fee paid by the Medical-Surgical Plan the surgical remuneration for the case and not the surgeon's fee. That was never the intention of the Medical-Surgical Plan of New Jersey, as evidenced by the fact that the assistant is free and eligible to send his separate statement on each service contract. Now, that would not be permissible if, in the spirit of the Medical-Surgical Plan, the assistant's fee was to be included in that surgical fee. I think that is the basis for Dr. Johnson's confusion.

Carrying that one step further, the assistant's fee is not now an eligible service for the Medical-Surgical Plan of New Jersey. The assistant should be compensated for his services and in doing so we will be increasing the services to the subscribers. I suggest that this Society recommend to the Commissioner of Banking that we increase our benefits to the subscribers and ask for a legal opinion from the Commissioner of Banking.

DR. MORRIS JOSEPH (Passaic): On this matter of fee-splitting and ghost surgery—I can almost define myself as an authority on the matter because I have been very close to it for the last fifteen or more years. This has become more and more vicious lately, more and more destructive to the entire profession and threatens to get even worse. I know places where it has turned into a real racket. And it's a pity that during these last twenty years, when rackets were so popular, that the medical profession had to stoop to the same type of practice.

The Medical-Surgical Plan and the Hospital Service Plan of New York—I don't know which it is or whether it was both—but it was reported in the New York Times that it has a deficit of two million dollars for 1953. New Jersey has been very fortunate in having a plan that has been very successful over a period of years now. Probably one of the very few state plans in the entire nation that has a Plan which has not gone bankrupt.

There is a tendency to bleed the Medical-Surgical Plan or the Hospital Service Plan. Patients are being sent into hospitals today

who could very easily be handled in the doctor's office. The hospital admission transforms a \$15 case into a \$150 case. It also consumes hospital beds which are needed for hospital cases, so to speak.

Now comes along this thought about whether dividing a fee into four or five parts is fee-splitting in the true sense of the word. I can't see why there should be such a quibble about this. If the accepted fee is to be divided among all of those who have participated in that procedure and it is done equitably and honestly by men who are genuine colleagues with us and who feel and think the same as we do, then why quibble so much? Why not accept it? Why not avoid adding additional burdens to the Medical-Surgical Plan or the Hospital Service Plan?

The Medical-Surgical Plan has been a boon to many of us and a boon to many people, and this is no occasion to waste a lot of time discussing trivial details. We are trying to read between the lines. If we are going to be suspicious of each other, we might just as well have no Plan at all and have no hospital service, no medical-surgical. If we can't trust each other and we can't depend upon our Board of Trustees of the Medical-Surgical group, who devote their time liberally and without remuneration, then there is no sense in having such a Plan. It is high time that all of us at least began to trust each other and those that work hard for the organization and the Society generally.

In some places doctors have been severely condemned by the press. I personally feel they deserved everything they got. And I'm not applying that to all the men in the profession; I'm applying it to those who are guilty. There was an article called "Certain Doctors Belong in Jail." I agree with that. The profession would be respected if we got rid of some of these blemishes. (Applause)

DR. ROBERT BRILL (Passaic): I think it is important for us to leave no ambiguity in the wording of a resolution as to how a surgical assistant shall be paid. The anesthetist is given a separate fee. The anesthetist does not spend any less time in the operating room than does the assistant. I see no reason why there could not be a separate fee for the surgical assistant. Then there would be no ambiguity. The surgical assistant will get a set fee, whether it be five dollars or twenty-five dollars. The doctors of New Jersey would once and for all be on record as tolerating no ambiguity as to the apportionment of fees.

Now, the actual dollars and cents of it could be worked out by statisticians of the Medical-Surgical Plan. This ambiguity should not be

permitted to persist. The wording "in addition" is the correct one rather than the wording "re-apportionment." (Applause)

PRESIDENT DECKER: Is there any further discussion on this amendment?

DR. MORICONI: Mr. Chairman, I ask for a secret ballot on the amendment.

PRESIDENT DECKER: The Chair rules that on this question a secret ballot is not necessary. (Applause) We will call for a show of hands. This is on an amendment to Paragraph Number 3: "I recommend that the fee made payable to the assistant be in addition to that already allocated to a medical, surgical, or obstetrical procedure, and to include pre- and post-medical, surgical, or obstetrical care." This is primarily an amendment to increase the total amount paid. It does not disagree with the *division* of the fee if it is increased.

DR. YAGUDA: By the statement that "the fee is in addition to that paid to the surgeon," that doesn't mean that the Medical-Surgical Plan has to continue the fee to the surgeon at the present level. They can set a lower level for the surgeon's fee and in addition pay the assistant.

DR. CORIO: That's absolutely right.

PRESIDENT DECKER: The Chair stands corrected. We interpret things with difficulty.

Are you ready to vote on the amendment? Are you ready for the question? This vote will be by a show of hands—the amendment which we have just read to be added to Paragraph 3. The Delegates—those with blue badges—the Delegates who are in favor of this amendment will vote by rising to their feet. Please rise.

Mr. Secretary, will you count them? I'll appoint you teller.

SECRETARY GREIFINGER: Sixty-five.

PRESIDENT DECKER: Now those who desire that this amendment be rejected, please rise.

PRESIDENT DECKER: I would say that the negative wins the vote.

PRESIDENT DECKER: The amendment has been rejected.

DR. MORICONI: Mr. President, House of Delegates: We just keep trying. About four years ago this subject first came up. There was considerable discussion on the advisability of introducing a plan of this type. It was decided that the Medical-Surgical Trustees would be guided by the action taken by the American College of Surgeons and the A.M.A. once the proposal was submitted to them. On the basis of the fact that since this most definitely is going to mean a profound change in our attitude towards the medical ethics observed in certain portions of the state, and in order to avoid this if possible and avoid

it even if possible, an unfortunate letter from other sources, I feel that Paragraph 3 should be amended to read the following: That Paragraph 3 be submitted for examination and approval by the American Medical Association and the American College of Surgeons and that the Medical-Surgical Plan Board of Trustees act in accordance with their recommendations.

PRESIDENT DECKER: Gentlemen, I'll rule that amendment out of order because we are not submitting to any other organization for opinion. (Applause) Pass to the next amendment.

DR. MORICONI: No. Begging his indulgence, I think the Chair is out of order. (Laughter)

PRESIDENT DECKER: The Chair is frequently out of order, but the Chair has ruled. (Laughter and applause)

DR. MORICONI: I request the Chair to call a standing vote on my motion to amend Paragraph 3 of this amendment as I stated, and for action of the entire Society on the matter. I'm not out of order. The House of Delegates can overrule any committee or any chairman.

PRESIDENT DECKER: As I understand the gentleman, he is appealing from a ruling of the Chair. We are perfectly willing to have the House of Delegates vote on any ruling that we make. I have ruled that his amendment is out of order. We are an autonomous body. We make our own decisions. We do not present them to any other group for their opinion or discussion. Shall we discuss this? I think not. We'll call for a vote on it right away.

DR. MORICONI: I don't know why we shouldn't be allowed to discuss the reason for it.

PRESIDENT DECKER: No reason for it.

All those in favor of supporting the Chair's decision will give a very weak assent. All those opposed to the Chair's ruling will give a very loud "No." The Chair is sustained.

DR. MORICONI: I bow to the Chair. (Applause)

PRESIDENT DECKER: Thank you.

Now we are still on Paragraph 3. If there is no further discussion, we will go to Paragraph 4.

DR. ERNEST F. PURCELL (Mercer): How are we going to handle private cases who are not Medical-Surgical Plan patients? What is our directive for them? What directive do we now have from our Society for other insurance cases? Are we to use the same formulation that the Medical-Surgical Plan presents for all other insurance cases and all other private cases that have no insurance? What is the directive?

PRESIDENT DECKER: The question is on the portion of the report of Reference Committee "C" on which a great deal of time was spent. The committee recommended that the resolution of the Mercer County Medical Society and the Hudson County Medical Society on the subject of division of surgical fees by Medical-Surgical Plan be rejected.

A DELEGATE: That wording was amended by Dr. Schaaf.

PRESIDENT DECKER: If everyone will quit whispering and let the Chair proceed, we will go on to accept the amendments that were made in the recommendations of Reference Committee "C" by Dr. Schaaf and which were voted by the Society.

Now the question is on this portion of the report of Reference Committee "C." The report of this committee is that the resolutions of the Mercer County Medical Society and the Hudson County Medical Society be rejected. They submitted certain recommendations for our discussion. It is not within the province of a Reference Committee to submit another recommendation. They recommend that we accept or reject the resolution submitted. This was submitted so that the thing could be discussed at greater length and aired completely and that is why the Chair did not rule it out of order at the beginning.

We are voting now on the report of Reference Committee "C" that the resolutions by Mercer County and Hudson County be rejected. They did not approve the resolutions as presented. That is the question.

Are you ready for the question? All those in favor will give the usual sign. All those opposed? The Ayes have it.

DR. GARDNER: Mr. Chairman, I move that the report as a whole be accepted.

(The motion was seconded.)

DR. HORLAND: Point of order.

PRESIDENT DECKER: Senator.

DR. HORLAND: I'm appealing to the Parliamentarian for a ruling. I appear before you now as a qualified, experienced politician, having attended many conventions of the American Medical Association; being the senior delegate from New Jersey to the AAGP, it gives me a chance to shake hands with Dr. Hewitt Smith here, who is also an AAGP man. I was proud to hear he was President of the Delaware Society.

A Reference Committee may adopt a resolution, deny a resolution or prepare a new resolution. Now, the reference committee in its wording—now, just pay attention, gentlemen, or all our work is for naught—the committee does not approve the resolutions as presented

but uses them as a basis for discussion and recommendations of the committee which appear later in the report. Now, it says: "Following a lengthy period of discussion of the problem of division of fees by Medical-Surgical Plan, the committee makes the following recommendations." Now, the committee must make a resolution if it rejects the resolutions that were presented and recommends but uses them as a basis for a new resolution. I appeal to the Parliamentarian for a ruling because in all the experience I have had, when a reference committee turns down two resolutions and then uses them as a basis for recommendations, those recommendations in effect are a resolution and it must so state.

PRESIDENT DECKER: The Chair rules that if the Reference Committee had decided to prepare a new set of resolutions, they would have done so. The Reference Committee has made recommendations which we have discussed at length. If they had not wanted these things discussed in detail, ad infinitum, the Chair would have at the beginning ruled that the recommendations were out of order. They can only present resolutions. And we have voted on the recommendation that the resolutions by the Mercer County Medical Society and the Hudson County Medical Society be rejected.

The question on the floor is the acceptance of the report as a whole. Now we are ready for the question if there are no more points of order.

DR. SCHAAF: Mr. Chairman, it is a matter of considerable concern to the Medical-Surgical Plan to determine the exact status of Paragraphs 1 and 2. We are not in opposition to them if they appear as declarations of policy. If they are declarations of policy and are not directed to the Medical-Surgical Plan, they should be broken out of this section of the report.

I would like to amend the motion to approve the report as a whole with the addition that Items 1 and 2 shall be listed separately from the recommendations to the Medical-Surgical Plan. They can appear later in some other category or even at the tail end of this report, but as it is set up now it is an integral part of the consideration of the report of the Medical-Surgical Plan and it is a declaration of policy and not requests. I would move that amendment.

PRESIDENT DECKER: This is an amendment to the report as a whole.

(The motion was seconded.)

PRESIDENT DECKER: We voted on 1, 2, 3, and 4 as a whole. There was no discussion when I called for it on Number 4.

DR. MORANDO DEFONZO (Essex): You did not call on 4. We were discussing the minority report first. You knocked down the minority report. Now we go back to the original report, and Number 4 is still wide open for discussion. You referred back to the original.

PRESIDENT DECKER: My Parliamentarian tells me that I should again ask you for discussion on Number 4. I did and everybody seemed to agree that that was proper practice. Now, anyone want to discuss Number 4?

DR. DUFFY: Point of order, Mr. Chairman. I don't believe we had a discussion on majority report Number 3. We discussed the minority report. The minority report was discussed, not the majority report.

PRESIDENT DECKER: The minority report was rejected.

DR. DUFFY: And then the amendment was discussed. We have not discussed the majority report.

PRESIDENT DECKER: We voted on it.

DR. DUFFY: No, sir, we have not.

PRESIDENT DECKER: You voted on Number 3.

DR. DUFFY: No, sir; we have not.

PRESIDENT DECKER: Gentlemen, before I become completely schizophrenic, my Parliamentarian tells me that we will now reopen Paragraph Number 3 for acceptance or rejection.

DR. DUFFY: The resolution in the majority report, Section 3, introduces a provision which will bring about a serious deviation from the accepted surgical practice. It is now common practice for the surgeon to attend the immediate pre- and post-operative care of his patient. If proposal 3 is accepted, the surgeon will then possibly be disassociated from the post-operative care of his patient, and then be remunerated for the services he performs. The surgeon is called in to perform the technical exercise of the surgical procedure; is paid for this procedure. Some one else is expected to be remunerated to take care of the post-operative care. Then it is only logical to assume that the operating surgeon will consider the man attending the post-operative care of this patient to be the proper authority. Now, I believe this evokes very serious possibilities.

We have been talking, in the Reference Committee, of appendices, hernias and so forth, but this embraces all branches of surgery. We must consider pneumonectomies, gastrectomies, prostatectomies and all the special technical post-operative knowledge associated thereunto.

Suppose we take, for example, the simple case of an appendectomy. The surgeon per-

forms the appendectomy. He feels there is need for, shall we say, retention sutures. His part in the case ends in the operating room. The referring doctor who attends the post-operative care of this patient is under the impression that the sutures should be removed in five days. The retention sutures are removed; the patient eviscerates. Now, gentlemen. I think this brings into consideration serious medico-legal aspects. The patient eviscerates. Say there is a major catastrophe and the patient dies. I want to know who is legally responsible for this patient's demise? Is the surgeon who had nothing to do with the post-operative care responsible, or is the man who was attending the patient post-operatively concerned?

Regardless of what the legal interpretation on that point may be, if this body entertains the possibility of division or allocation of fees and considers the *responsibility* divided, then it must state its position so that in later cases they may be called upon to render its interpretation in a court of law.

(Applause)

DR. FRANCIS M. CLARKE (Middlesex): Mr. President, Ladies and Gentlemen: Dr. Duffy has anticipated me. I was trying to get the eve of the Chairman before. The question which he has raised I think is a very important one.

There are many forces at work in the state attempting to improve the quality of surgical care. If there is any virtue in attempts at self-improvement, it is also true that some forces are working in the opposite direction because if special information has any value, it can only be obtained by special application.

I don't know how this vote is going to go. The proposal may be accepted, it may be rejected, but in any event it has serious implications. And if it should be accepted that referring physicians or other physicians have a stated financial participation or responsibility for the care of the patient for that particular illness at that particular time at that particular admission to the hospital, then there is also a strong implication that he is responsible, as Dr. Duffy has said, for the pre-operative and the post-operative care which has been enumerated here. It is certainly not proper to assume that surgery consists only of operating. Surgery consists in the care of a patient for conditions which are amenable perhaps to operating, but it does not begin or does not end in the operating room.

We are all familiar with many instances of disaster which have come from the idea of divided responsibility. I have personal knowledge of numerous instances in which each per-

son assumed that the other one was going to do something and neither one did it or one of them did it improperly and disaster resulted. Somebody must be in charge regardless of the action which this body takes at the present time. I suggest that nothing in the foregoing shall be meant to imply any change in the traditional responsibility of the surgeon in the care of the patient.
(Applause)

PRESIDENT DECKER: Dr. Clarke called our attention to some of the implications of these recommendations. He did not submit an amendment. We are now ready for the question on Paragraph 3. Are you willing to vote on it now?

DR. SHARP: Mr. Chairman, you did not vote on 1 and 2, unless I am incorrect.

PRESIDENT DECKER: We did. I will maintain we voted on 1 and 2. Beyond that I won't go. I will call for a motion to approve Paragraph 3.

DR. CLARKE: Mr. Chairman, I move that an amendment to the third paragraph be made to state that nothing in the above shall be assumed to imply any change in the traditional fixing of responsibility on the attending surgeon.

(The motion was seconded.)

PRESIDENT DECKER: The amendment has been stated. It has been seconded. Are you ready for the question? You mean there is no further discussion? All those in favor of the amendment say 'Aye'! All opposed?

Dr. Clarke, your amendment is carried. We are in complete agreement with you.

Now we will ask for a motion on Paragraph Number 3 as amended.

DR. KAUFMAN: I so move.

(The motion was seconded.)

PRESIDENT DECKER: Are you ready for the question? All those in favor? Opposed? The Ayes have it.

Now we are going to Paragraph 4, which reads: "Each physician who participates actively in the care of a patient shall send his bill for services separately to the Medical-Surgical Plan for payment."

(Motion to adopt was made and seconded.)

PRESIDENT DECKER: Is there any discussion? Are you ready for the question? All those in favor? Opposed? That was unanimous.

DR. GARDNER: Mr. Chairman, I recommend the acceptance of this report as a whole, and as amended.

(The motion was seconded.)

DR. HORLAND: Point of order. The approval of this portion of the report and the adoption of the whole, now transforms these four para-

graphs into recommendations. Is it proper, with the consent of the House of Delegates, to introduce a resolution and make this in the form of a resolution so that it will be definitely established as a policy of this body?

PRESIDENT DECKER: It could only be done by unanimous consent. If you will ask for unanimous consent to introduce the resolution, I'll be very glad to put it to the House.

DR. HORLAND: All right. I ask for unanimous consent of the House to introduce this portion of the report as a substitute resolution for those that were not approved.

PRESIDENT DECKER: Unanimous consent is requested to introduce a new resolution. All those in favor of this will say 'Aye.' All those opposed?

Your motion is lost, Doctor. I'm sorry.

DR. MORICONI: Mr. Chairman, I would like to add to the motion as stated by the Chairman of the Committee. I suggest that a copy of this report be sent to the American Medical Association and the American College of Surgeons.

PRESIDENT DECKER: Doctor, you have the privilege of mailing this to them when you receive them. We will furnish extra copies to you. (Applause) We are an autonomous body; we are not subject to any other organization in the country. (Applause)

DR. MORICONI: I made a motion in which I asked something be added to the report. There is nothing in the rules of order that say I'm wrong. I ask that a copy be sent to the A.M.A. and the American College of Surgeons. The House can reject my request. If so, that settles the issue.

(The motion was seconded.)

President Decker: Gentlemen, the integrity of your Chairman has been again questioned. We must ask for a vote of confidence. (Laughter) If you are in agreement with my decisions, will you indicate by rising? (A number arose.) Thank you. If you are in disagreement, will you rise? (A few arose)

There are a number in disagreement with us, but I'm afraid there are more who agree with me.

DR. SCHAAF: I move that the motion be amended to read that Items 1 and 2 be separated from 3 and 4; that 3 and 4 appear as part of the report referring to the Medical-Surgical Plan, and that 1 and 2 appear elsewhere in an appropriate place.

PRESIDENT DECKER: Is there a second to this amendment?

(The motion was seconded.)

PRESIDENT DECKER: Is there any discussion on this amendment?

A DELEGATE: I don't think we are concerned with the Medical-Surgical Plan at all and I think if we leave it out of it it will make things much simpler. These are recommendations and they are going to be made in the form of a resolution and it is not directed to the Medical-Surgical Plan. It's a statement of policy.

PRESIDENT DECKER: The amendment is that Paragraphs 1 and 2 be separated from Paragraphs 3 and 4 in the recommendations of Reference Committee "C." Now the question is on the amendment. Do you want to so amend the report of Reference Committee "C"? All those in favor give the usual sign; all those opposed. The Noes have it.

Now the question is on the original motion of Dr. Gardner, which he has so patiently restated for us so many times. The question is on the acceptance of the report of Reference Committee "C" as a whole, as amended. All in favor give the usual sign. Opposed? So ordered.

Now, may the Chair ask for a motion of thanks from the House of Delegates to Dr. Gardner and his Committee for their effort and time and labor—a rising vote?

(The Delegates arose and applauded.)

DR. HORLAND: I have been on many reference committees. I heartily endorse the motion made by our President, and I want to tell you that Dr. Kenneth Gardner did a voluminous job. (Applause)

DR. DECKER: Gentlemen, we have a number of reports that are important to the Society. I declare a brief recess.

(After a short recess, the meeting was resumed.)

PRESIDENT DECKER: The House of Delegates will be in order. Do we still have a quorum?

SECRETARY GREIFINGER: Mr. President, we do have a quorum.

PRESIDENT DECKER: The next order of business will be the reception of the report of Reference Committee "D." Dr. Crandell.

(Dr. Crandell read the report of Reference Committee "D," now in Appendix D, which was adopted, section by section, upon motions regularly made, seconded and carried.)

DR. CRANDELL: Mr. President, I move the acceptance of the report as a whole.

(The motion was seconded.)

PRESIDENT DECKER: You have heard the motion. Are you ready for the questions? All those in favor give the usual sign; opposed. It is so ordered. Thank you, Dr. Crandell.

The next order of business is the receipt of the report of Reference Committee "E." Dr. Robert Bowen.

(Dr. Bowen read the report of Reference Committee "E," which was adopted, section by section, upon motions regularly made, seconded and carried. This is printed in Appendix E.)

DR. BOWEN: I move the approval of the report in toto.

(The motion was seconded.)

PRESIDENT DECKER: It has been moved and seconded that the report of Reference Committee "E" be accepted as a whole. Are you ready for the question? All those in favor give the usual sign; opposed. So ordered.

Doctor, your report is unanimously approved.

The next order of business is the report of the Reference Committee on Constitution and By-Laws. Dr. Saffron.

(Dr. Saffron read the report of the Reference Committee on Constitution and By-Laws. This is in Appendix F.)

DR. SAFFRON: Mr. President, I move you the acceptance of the report of the Reference Committee on Constitution and By-laws.

(The motion was seconded.)

PRESIDENT DECKER: It has been moved and seconded that the report of the Committee on Constitution and By-laws be accepted. Are you ready for the question? All those in favor give the usual sign; opposed. So ordered.

Thank you, Dr. Saffron.

Now we will go on with the report of the Reference Committee on Miscellaneous Business. Dr. Coughlin.

DR. JOHN P. COUGHLIN: The Reference Committee on Miscellaneous Business met at 2:00 p.m. on Monday, May 17, 1954. All members were present.

"1. The Committee accepts the recommendation of the Board of Trustees that the next annual meeting be held at the Ambassador Hotel, Atlantic City, New Jersey, April 17-20, 1955."

Mr. President, I move the adoption of this portion of the report.

(The motion was seconded.)

PRESIDENT DECKER: All those in favor say 'Aye.' Dr. Allman votes "Aye" very loudly in my right ear. Opposed. Do I hear any opposition? I'm afraid I'll have to rule that that motion is carried.

DR. COUGHLIN: "Number 2. The Committee moves the acceptance of the report of the Scientific Program Committee; namely, 'Each section shall limit itself to two out-of-state speakers. No section shall expend more than \$100 for the expenses of its speakers'."

Mr. President, I move the adoption of this portion of the report.

DR. KAUFMAN: Does that include the general section?

PRESIDENT DECKER: I know what Dr. Kaufman is going to talk about. No section can have more than two out-of-state speakers. No section shall expend more than \$100 for the expenses of both speakers or each speaker. I

want to be sure we know what we are voting on. We are voting on the motion which is Paragraph Number 2 in your report from the Reference Committee on Miscellaneous Business.

DR. PURCELL: Does that mean they only have out-of-state speakers?

PRESIDENT DECKER: No. A section is limited to two out-of-state speakers. They can have just as many papers as they want, but only two speakers may come from outside New Jersey. The section will not expend more than \$100 for the expenses of one or both speakers. Is that clear?

A DELEGATE: Is that \$100 for each speaker?

PRESIDENT DECKER: No. It's \$100 for the committee to spend for one speaker or for two speakers, but it is limited to \$100 for their speakers.

A DELEGATE: May I make it \$100 for each speaker? I think you will get better speakers. The way things are now, it's too low.

PRESIDENT DECKER: We do not pay an honorarium to these speakers, you must remember that. This is for their expenses.

DR. GEORGE A. MATHEKE (Essex): I realize that, but if a man comes to make a talk to this group, his expenses are naturally in excess of \$100, which is too much to ask these men to forfeit their time and money as well.

PRESIDENT DECKER: Are you submitting that as an amendment to the motion?

DR. MATHEKE: I am.

(The motion was seconded.)

PRESIDENT DECKER: We are voting on the amendment suggested by Dr. Matheke. Are you ready for the question on the amendment, that the expenses for out-of-state speakers shall be \$200 instead of \$100?

DR. MATHEKE: The way I intended was a hundred dollars for each speaker. If they have one speaker, an allowance of \$100.

PRESIDENT DECKER: Well no. You are not allowing money to the speakers; you are paying expenses for their travel. If you have a fellow come from California and one come from New York, their expense account is entirely different. Now, my interpretation of your amendment is that you are raising this to \$200 from \$100. You feel we might be able to get better speakers if we had more money to pay their expenses. That is a perfectly reasonable thing. I have asked that question myself.

Now, that is the amendment upon which we are voting. Are you ready for the question? All those in favor? Opposed? I am going to have to call that again. That "no" was too loud in my ear. (Laughter)

All those in favor of this amendment which increases the fee from \$100 to \$200, the ex-

pense, will vote "Aye;" all those opposed will vote "Nay."

Gentlemen, I'm awfully sorry that I am apparently delaying things here with the abetment of Dr. Allman. We will have to ask for a rising vote.

All those in favor of increasing the amount from \$100 to \$200 will please rise. Delegates only.

SECRETARY GRIEFINGER: Seventy-three.

PRESIDENT DECKER: All right, gentlemen, you may be seated.

All those opposed to this increase will please rise.

SECRETARY GREIFINGER: Fifty-two.

PRESIDENT DECKER: Fifty-two standing, plus Dr. Allman, makes fifty-three opposed; seventy-three for the increase, which makes Dr. Allman's heart bleed. And if he had not voted so loudly "No," I would have been able to hear the first vote.

DR. SHARP: Mr. President, you forget it makes Mrs. Madden's heart bleed. This comes out of the Convention Fund, not out of our fund. It does not come out of the budget; it comes out of the Convention Fund. She wants to know where she is going to get the money.

PRESIDENT DECKER: That is a problem that could be discussed *ad infinitum*; where can anyone get money?

Now the question is on the motion to accept Paragraph 2 as amended. Are you ready for the question? All in favor give the usual sign. Opposed? The Ayes have it.

(Dr. Coughlin then read the balance of the report, which was adopted, section by section, upon motions regularly made, seconded and carried. This is Appendix G.)

DR. COUGHLIN: Mr. President, I move the adoption of the report in full together with the amendment to Number 2.

(The motion was seconded.)

PRESIDENT DECKER: Are you ready for the question? All those in favor give the usual sign; opposed. So ordered.

Thank you, Dr. Coughlin.

DR. C. ARCHIE CRANDELL: Mr. President, I notice inadvertently one section was left out of Committee "D"'s report. I'd like permission to correct that.

PRESIDENT DECKER: You mean as submitted to us?

DR. CRANDELL: Yes.

PRESIDENT DECKER: The Chair will rule that Dr. Crandell can submit a paragraph that was, by a typographic error, left out of his report and the proof-reader just found it.

DR. CRANDELL: "The Committee recommends that the National Casualty Company, through the representation of E. & W. Blank-

steen, be continued because it has served us well and its policy is the best offered for group protection." I'd like to include that in the report of Reference Committee "D."

(The motion was seconded.)

PRESIDENT DECKER: Are you ready for the question? All those in favor give the usual sign; opposed? So ordered.

DR. CRANDELL: I'd like to move that the report as amended now, as a whole be accepted.

(The motion was seconded.)

PRESIDENT DECKER: All those in favor give the usual sign; opposed? So ordered.

Thank you, Dr. Crandell.

Now we have the report of the Reference Committee on Resolutions and Memorials. Dr. Cottone.

(Dr. Cottone read the first paragraph, "Honorary Membership," of the report, which was adopted upon motion made, seconded and carried. He then read "Emeritus Membership." See Appendix H.)

Dr. Deutsch: I'd like to ask what happened to the names that were submitted from Union County. I believe we had two or three members up for emeritus membership.

DR. COTTONE: They were not received by our Committee.

SECRETARY GREIFINGER: The Secretary's office did not receive them.

PRESIDENT DECKER: We are voting on Dr. Cottone's motion to approve this portion of his report. Are you ready for the question? All those in favor give the usual sign. Opposed? So ordered.

(Dr. Cottone read the paragraph on "Hospital Offenses," which was adopted on motion regularly made, seconded and carried. See Appendix H.)

DR. COTTONE: I move, Mr. President, for the acceptance of the report of the Reference Committee on Resolutions and Memorials in toto.

(The motion was seconded.)

PRESIDENT DECKER: All those in favor give the usual sign. Opposed? So ordered.

Thank you, Dr. Cottone.

DR. JEROME G. KAUFMAN: I'm appearing before the House of Delegates now as Chairman of the Annual Meeting for next year. Realizing that with the increase from \$100 to \$200 to defray expenses for speakers may cost us an additional \$2,000 which we don't have, I am here to make a motion for reconsideration of Dr. Matheke's motion.

DR. YAGUDA: I second that.

PRESIDENT DECKER: It has been moved and seconded that we reconsider Dr. Matheke's amendment to the report of the Reference Committee on Miscellaneous Business. The amendment to the report, which increased the money from \$100 to \$200, is now reopened.

DR. KAUFMAN: I would like to appeal to this House to consider the fact that this is not part of the state budget.

DR. MATHEKE: Mr. Chairman, in view of the fact that there seems to be a question as to the money involved, I'll be happy to withdraw my motion.

PRESIDENT DECKER: You can't withdraw it. It has been passed. You make a motion.

DR. MATHEKE: I move that the fee be set at \$100.

PRESIDENT DECKER: Thank you. Is that seconded?

(The motion was seconded.)

PRESIDENT DECKER: Are you ready for the question? All those in favor give the usual sign. Opposed? So ordered.

Mr. Secretary, is there any unfinished business before the House of Delegates?

SECRETARY GREIFINGER: No.

DR. YAGUDA: Mr. Chairman, we are not prepared to announce the Scientific Exhibit Awards as yet. They will be published in an early issue of the JOURNAL.

PRESIDENT DECKER: Thank you, Dr. Yaguda.

Now comes the time when we must introduce our recently elected officers, and it is my particular and peculiar privilege to be permitted to introduce your newly elected Second Vice-President. I have known him for many years, ever since he came to our hospital in Camden as an intern from the Medical College of the University of Maryland. We have always liked him. We have a high regard for him, and I am going to ask him to stand up so that you can see him and accept my word that he is a very fine, capable gentleman and fulfills all the requirements and high traditions that go with the presidential office of this Society. Dr. Kump.

(Applause)

Now we come to another part of this program. We are involved with symbols in our affairs. We have to introduce you formally to a man whom you have known for a long time and who has served this Society for a long time, but for the purposes of the record, and whatever other purposes are necessary, it is my very great privilege to ask Dr. Weigel to come forward to stand at this lectern and to introduce the man to you. Dr. Weigel.

(Applause)

DR. ELMER P. WEIGEL: Mr. President, Members of the House of Delegates, Ladies and Gentlemen: This is a very happy privilege that is accorded me today, and I am grateful for the opportunity to render this service to an outstanding member of this honorable body.

A man's success in worthy enterprise is never cause for joy to him alone. By the nature of his accomplishments good occurs to his fellow men and as a result of these benefactions joy is the lot of all who appreciate the man and his accomplishments. Especially is this true of his friends because a man's friends rejoice in the good that he attains and the good that he does.

There is much joy in the hearts of the members of the Union County Medical Society today as there is properly such joy in the hearts of the members of The Medical Society of New Jersey because of the character of the man who today assumes the leadership of organized medicine in the oldest medical society in the United States.

It is my happy privilege to be the voice of that joy to give tongue to the satisfaction that we all experience as Elton Wallace Lance assumes office as the one hundred sixty-second President of The Medical Society of New Jersey.

Dr. Elton W. Lance was born in Cabot, Vermont, the son of Walton Byron Lance and Louise Bates Lance shortly before the turn of the century. He received his premedical and medical training at the University of Vermont which awarded him his Doctorate in Medicine in 1924. After an internship at the Mary Fletcher Hospital in Burlington, Dr. Lance entered the practice of medicine in Rahway, New Jersey, where he continues to reside, specializing now in general surgery.

In World War II Dr. Lance joined the Army Medical Corps as a volunteer in 1942 with the rank of Major. He served with the Iceland Base Command for two and a half years as Chief of Surgery and Executive Officer of the 49th Station Hospital. He was discharged in 1945 with the rank of Lieutenant Colonel.

He has been a member of the attending staff of Rahway Hospital since 1926. He has been President of that staff and for several years Chairman of its Executive Committee. As President of the Union County Medical Society he served with credit in 1946 and 1947. He has been a member of the Board of Trustees of The Medical Society of New Jersey since 1946, a member of the American Medical Association, Fellow of the American College of Surgeons, the Society of Surgeons of New Jersey, and the Academy of Medicine of New Jersey.

He has been actively interested in voluntary health insurance programs since their inception. In 1937 he was made Chairman of the Committee on Voluntary Health Insurance which became the founding committee of the

Medical-Surgical Plan of New Jersey and the Medical Service Administration. When these organizations were incorporated he became the first President of both groups. He served in this capacity until entrance in the military service in 1942 required his resignation. Since his return from military service he has been a trustee of both Medical Service Administration and Medical-Surgical Plan.

Dr. Lance married Ruth Helen Brown, daughter of Dr. and Mrs. E. M. Brown of Sheldon, Vermont, in 1925 and they are the proud parents of two worthy sons, Dr. Edward M. Lance, a graduate of Johns Hopkins Medical School, and Dr. Kendrick Page Lance, a graduate of Harvard Medical School, both of whom are now serving with the United States Navy.

In a time of great need here is a leader of ability and integrity, in a crucial hour here is a man who knows the way. We of Union County are proud to claim him as our own and happy to share him with all of you.

I am honored, ladies and gentlemen, to present to you the one hundred and sixty-second President of The Medical Society of New Jersey, Dr. Elton Wallace Lance.

(The Delegates arose and applauded.)

PRESIDENT-ELECT LANCE: Members of the House of Delegates of The Medical Society of New Jersey, and Friends: Very briefly I would like to say that I again repeat that it is with a great sense of honor and pride, but with a great sense also of humility and the consciousness of responsibility which this office carries that I accept that responsibility, and I thank you very much indeed for the honor.

(Applause)

PRESIDENT DECKER: If I have committed any errors, they have been of omission rather than commission. I hope that I may be forgiven for them. With two Parliamentarians, backed up by the best one in the state, Dr. Schaaf, I have been in trouble all morning.

(Laughter)

Two or three things. May I please announce to you that the scientific exhibits are on the upper lounge floor. They are separated from the commercial exhibits. Please go through them.

The reorganization meeting of the Board of Trustees of The Medical Society of New Jersey will be held at 12:30 p.m. in the Bakewell Room, Haddon Hall, on Wednesday, May 19.

Now, having pleaded with you for your indulgence, may I thank you for having permitted me to serve. And may I ask for a motion for adjournment?

(Upon motion duly made, seconded and carried, the meeting was adjourned at 12:45 p.m.)

GENERAL SESSION I

Monday Evening, May 17, 1954

The General Session of The Medical Society of New Jersey convened May 17, 1954, at Had-don Hall, Atlantic City, at 9 p.m., President Henry B. Decker presiding.

PRESIDENT DECKER: The General Session of The Medical Society of New Jersey will be in order.

May we rise for the National Anthem?

(The audience arose while the orchestra played the National Anthem.)

PRESIDENT DECKER: A year ago The Medical Society of New Jersey conferred upon me a stewardship. At the proper places and at the proper times I have accounted for this stewardship. Whether it has been good or bad, time will tell. I have attempted to accomplish things to the best of my ability. I have at times let things lie fallow because the good husbandman is one who lets his fields rest so that later on they may produce better crops and more fruitful crops. I hope that my successor will be able to take advantage of these things.

I have had a very pleasant time in my association with this Society, particularly as the President of the Society. It has not been too time-consuming, too toilsome; it has been completely enjoyable. And except for the attacks of gout that I have suffered because I have had to over-drink and over-eat on various occasions, I have not had too much trouble.

My successor, who will speak to you, is a physician whom you know well. He has served the Society faithfully for many years. Talking to him the other day and recalling things that we had done, we remembered that we started to serve the Society some twenty years ago, in 1933 or 1934, on the Hospital Relationships Committee under the late Dr. Thomas Lewis, and about the time we started to serve the Society a fee insurance program was set up in New York City. It was a local program and Dr. Lance was detached to study it. His study and report to that Committee led to our present-day Medical-Surgical Plan in New Jersey which is the oldest one in the country and has been consistently successful, although the managers of that program have been hit by every brick that could be thrown by any commission in the State.

Dr. Lance has ideas which he will attempt to put into operation, which I know will be successful. They will redound to the benefit of The Medical Society of New Jersey, to the practitioners of medicine in New Jersey, and to the

most important individual in New Jersey: the patient. Dr. Elton Lance.

(Applause)

PRESIDENT-ELECT ELTON W. LANCE: Mr. President, Most Welcome Guests, Ladies and Gentlemen of the Convention: Twelve years short of two centuries ago, The Medical Society of New Jersey was established. The purpose for which our physician ancestors banded together was, in their own words, "to form a Society for mutual improvement, the advancement of the profession, and the promotion of the public good." The order of that enumeration was no mere accident of composition. It indicated the logical progress toward their goal—through mutual improvement to the advancement of the profession, and thence to the promotion of the public good. For twelve years short of two centuries, under a succession of 161 presidents, The Medical Society of New Jersey has been faithful in the pursuit of that three-fold ideal. It is my solemn and earnest pledge, given in a spirit of proper pride and genuine humility, to do all in my power, as the 162nd President of this venerable and distinguished organization, to carry on toward the same ends, with the help of my fellow physicians and with the help of God.

The task of the physician has never been a light one. His ambition, born of his desire to serve his fellowmen, necessitated his attacking, with the instrumentalities of his questing mind, the mountains of ignorance that had to be leveled before he could lead the way to freedom from the thralldom of disease, and to the attainment of a long life of good health for all.

His energy and courage had to be such, in early times especially, as would sustain him in the face of what he conceived as hostile nature and angry gods. His valor had always to equal, if not to surpass, his vision. The chronicle of his achievement is the chronicle of his glory; and, in this our day, it is written as it has never been written before, in the story of life that is long and rich in the blessings of health, which the average man of today is privileged to enjoy.

The shadowy pestilences and plagues, the scourges and miasmas, the mysterious seizures and visitations, that in darker days cast the blight of their power over the life of man have, we hope, been forever banished. And the relatively few diseases that remain to harry us, we have high and well-founded hopes of soon bringing under control. Thus the drama of

medicine today moves into a new phase—from the struggle to overcome diseases to the struggle to preserve good health. The work is no less challenging; the reward no whit less satisfying. This certainly is no time for resting. For all of us much work remains, "not unbecoming men that strove with gods."

Progress in the sphere of international and socio-economic relations has not kept pace with the progress of medicine and the allied professions. In large part, though health has been so well served, the general good of man, which is measurable in terms of his peace and happiness, leaves much to be desired. And, may I remind you, as members of The Medical Society of New Jersey we are dedicated, by the declaration of our founders, not merely to the promotion of the public health but to the promotion of the public good. Moreover, apart from our professional commitment, as citizens of the United States and inhabitants of the unhappy world of today, what affects the public good affects all of us as individuals. So the problems of the vexed economy of our times are our problems also. The rueful fact is that a healthy man can still be miserable. In fact, being healthy he is frequently more vitally miserable than he would be if he were reduced to apathy by disease.

Medicine has not created the economic conditions under which people groan. Bad government the world over and the fantastic cost of war and the armaments of war, coupled with an encouraged philosophy of individual irresponsibility and selfishness are largely to blame.

In the interest of the public good we must be as alert to discover and as energetic to eliminate ills of the spirit as ills of the flesh. We must preach, for the preservation of the public good, the importance of the development of citizens whose character is such—in the best of the American tradition — that they live proudly by their own strength and survive by their own vigors. We must proclaim the importance of the development of citizens from whom the government derives its strength and security and not citizens who are content to be the dependent recipients of the bounty of the state. In the interest of the public good — and of the preservation of a free America as a symbol and a hope to an oppressed world—we must preach the pre-eminent importance of the qualities of personal integrity, personal responsibility, and mutual cooperation—and we must practice what we preach!

To that end in The Medical Society of New Jersey we will continue—not only in the year upon which we now enter, but I hope in all the

years that are to be—to encourage mutual improvement, to advance the profession, and to promote the public good. We will do these three things by every means possible.

Our mutual improvement will be encouraged, as in the past, by the enforcement of high standards of professional competence, by strongly supporting and improving medical education and training at all levels, by stimulating scientific research and by sharing scientific knowledge, and by generating a respect for quality and excellence in the doctor both as a physician and as a member of society.

The advancement of the profession will follow upon the dutiful and dependable service rendered by competent practitioners who individually bring to their ministrations the fervor of science and the compassion of human brotherhood. Collectively we will strive so to organize, integrate, and correlate our activities in the State and component county societies that all members will have a sense of active participation in and responsibility for the policies and procedures of organized medicine in New Jersey. To achieve such organization this year, with the approval of my fellow officers and of the Board of Trustees, on an experimental basis, I propose reconstituting as special committees certain advisory committees whose work is of a continuing character, and eliminating other advisory committees whose interests will be dealt with for this year at least, directly in the subcommittees which previously they served. The subcommittees involved will be proportionately expanded to provide and insure adequate personnel for the efficient and well-balanced handling of all matters, and the proper protection of all interests.

In all these ways, and by all these means, by the furtherance of all policies, programs and procedures already adopted and the improvisation of such new ones as prove necessary, we will continue to promote the public good. In every way, and at all times, we will encourage our members—as physicians and as conscientious citizens—to give of their abilities and of their energies, in community and civic as well as in professional undertakings, to advance every effort that is in the interest of the public good, and to oppose vigorously everything that places it in jeopardy.

This is the day of the embattled physician, as it is the day of the embattled man of principle and of honor. It is not a day in which the lofty rules of war or of controversy are much regarded. Nevertheless, I call upon the members of The Medical Society of New Jersey, in the name of the best of the past and of the present, to give themselves to the fray. They will not fight alone.

In closing I would like to recall to the embattled physician of today the sage advice of Rudyard Kipling's "IF." It seems to me particularly appropriate in these trying times.

If you can keep your head when all about you
Are losing theirs and blaming it on you,
If you can trust yourself when all men doubt you,
But make allowance for their doubting, too;
If you can wait and not be tired by waiting,
Or being lied about, don't deal in lies,
Or being hated, don't give way to hating,
And yet don't look too good, nor talk too wise;

If you can dream—and not make dreams your
master
If you can think—and not make thoughts your
aim;

If you can meet with Triumph and Disaster
And treat those two imposters just the same;
If you can bear to hear the truth you've spoken
Twisted by knaves to make a trap for fools,
Or watch the things you gave your life to, broken,
And stoop and build 'em up with worn-out tools;

If you can make one heap of all your winnings
And risk it on one turn of pitch-and-toss,
And lose, and start again at your beginnings
And never breathe a word about your loss;
If you can force your heart and nerve and sinew
To serve your turn long after they are gone,
And so hold on when there is nothing in you
Except the Will which says to them: "Hold on!"

If you can talk with crowds and keep your virtue,
Or walk with Kings—nor lose the common touch,
If neither foes nor loving friends can hurt you,
If all men count with you, but none too much;
If you can fill the unforgiving minute
With sixty seconds' worth of distance run,
Yours is the Earth and everything that's in it,
And which is more—you'll be a Man, my son!

And, ladies and gentlemen, today the world is sorely in need of men—good men — such as The Medical Society of New Jersey and the medical profession can generously supply. Thank you. (Applause)

PRESIDENT DECKER: A Constitutional requirement of The Medical Society of New Jersey is that the retiring President shall prepare and present an address. This practice continued for many years, but with the competition of radio and television and the McCarthy hearings, people became educated to good amusement, so that the Presidential address becomes a token. Instead of the Presidential address we are permitted to invite a trained speaker who can think and express himself to carry out this duty for us.

When my ancestors came to this country, after having been run out of New Amsterdam because they had advised its surrender to the British, and then went to Fort Orange at Albany and advised them not to surrender to

the British, they were chased into the back countries and wound up in the Minisink area, which is above the Delaware Water Gap, where they lived peacefully for many years.

The movement from colonial times had always been to the West, toward New York, Ohio, Iowa, Minnesota and Oklahoma. I am the only one who ever moved toward the East and landed in South Jersey.

But there is a very interesting similarity between the Minisink Area and South of the Rancocas. In both areas we have kinfolk, cousins and kissin' cousins.

The speaker of this evening is a young man who married one of my kissin' cousins. After he married her he went on to become Vice-Chairman of the Board and General Counsel of the United States Steel Corporation. He is going to talk to you about an interesting problem in economics. When he uses the term "Dr. Harry," he means me because my kinfolk call me that, so disregard that when you hear it. Mr. Roger Blough.

(Applause)

MR. ROGER BLOUGH: Dr. Decker, Dr. Lance, Members of The Medical Society of New Jersey, and Fellow Guests: No doubt you are wondering why a member of the bar, who has become hopelessly enmeshed in the steel business, should undertake to speak at a medical convention. Frankly, I am wondering exactly the same thing myself.

When my good friend—shall I call him Henry or Harry or Dr. Harry?—invited me to take part in the program here tonight, he told me that his only duty, as President of your distinguished and venerable Society, was to select a speaker for this meeting. I hope, for his sake, that that is not entirely true, for I shudder to think what future historians may say about the Decker Administration if they are forced to base their appraisal of it solely upon the questionable judgment which he displayed in fulfilling this assignment.

A more considerate man than I might have sought to protect the good doctor from the consequences of his folly by suggesting that he find a stouter reed to lean on; but it is the misfortune of the members of my profession that we must frequently cope with the indiscretions of others; and the opportunity to participate in this 188th annual meeting was an honor and a privilege that I could not bring myself to put aside—even in defense of the sterling and hitherto untarnished reputation of your President.

In further extenuation of my presence here this evening, I should explain perhaps that many years ago, when I was very young, my mother gave me a piece of advice which has always

impressed me as being worthy of King Solomon himself:

"My son," she said, "the older you grow, the more you will appreciate the wisdom of striving to live at peace with the Lord and on good terms with the medical profession."

(Laughter)

So I have never forgotten that it is always hazardous to say "no" to a doctor. Not until tonight, however, did I fully appreciate what the wives in this audience have known all along—that it may be equally hazardous to say "yes."

Now that I am here, what to talk about when suddenly confronted by the infinite store of knowledge and wisdom represented here in this room?

With, medically speaking, an apprehensive eye to the future, but an appreciative eye to the past, I cannot possibly venture into the field of medicine—much as I should like tonight to review some of the many scientific miracles which your fraternity has worked within the span of my own lifetime. As an example, since arrival I learned that Dr. Fritts had discovered a method of inducing a human allergy for cows. I may say it is not patentable and involves a direct application, but he says it is very effective.

I asked Henry if he wanted me to talk about steel. He said it reminded him of the little boy in the cartoon who asked his father a question. His father, busy with his newspaper, said: "Why don't you ask your mother?" His son replied, "I just don't want to know that much about it." So you now understand why I can't talk about steel.

(Laughter)

But there is one topic which is being universally debated throughout the world these days, and which is of vital importance to every one of us in every profession, every industry and every walk of life. And it is especially appropriate on this occasion, I think, because it is a question of health—the economic health of our country.

We have been in a slump lately. Our pep and energy aren't what they were at this time last year. Our metabolism is down. Our blood pressure is low. We've been having a lot of headaches and the aspirin business is booming. So we're worried about it.

In fact, some one has observed that we're so worried about it that we take our economic pulse every five minutes, our temperature every ten, and that, as a nation, we are well on our way to becoming a confirmed hypochondriac.

Now that is deplorable, perhaps, but not necessarily fatal. What concerns me most deeply is the appalling profusion of economic

medicine men who are trying to treat the patient. They include labor leaders, businessmen, politicians, farmers, housewives, and, of, course, economists—both foreign and domestic. It would not even surprise me if there were a doctor in the crowd.

But whatever their vocation, each of these self-qualified practitioners is blissfully confident of his ability to diagnose the ailment correctly and to prescribe the cure. The diagnoses differ widely, and the proffered prescriptions range all the way from a shot in the arm to a major operation requiring inflationary anesthesia.

Now, I am not an economist, and I shall not compound confusion by advancing any theories or nostrums of my own. But I would like to say a few words in behalf of the patient, because the patient in this case is every one of us, and the time has come, I think, when we ought to speak up while we are still able.

We must never forget that America's economic health is probably the most important thing on the face of this earth today. If we can keep our economy strong and vigorous, we may, with God's help, avert a war of annihilation. If we permit it to become weak and flabby, we invite disaster. It could be as simple as that.

So it is not only our own future, but the world's future, which is at stake in this controversy; and we cannot afford to fall into the clutches of self-serving medicine men who are interested only in foisting upon us their own particular brands of snake oil and swamp water.

Rather, I propose that here in this room—among men and women who are schooled in science and whose lives are dedicated to their fellow men—we should ignore for a little while the voices of the special pleaders—of ambition and of partisanship—and try, if we can, to view some of the facts of the case in the cool, refreshing light of dispassionate reason.

Now, it goes without saying, I think, that the sum total of our national welfare is nothing more nor less than the sum total of the economic health and vigor of every person in this country. If all of these people thrive and prosper, so does America; and the stronger they become, the stronger becomes our whole national economy.

In recognition of this basic fact, there is now before Congress a program of economic incentives designed to stimulate each individual, in every occupational group, to do a little better for himself—to produce more, to earn more, and thus to be able to buy more. For the sake of convenience, and for the purposes of identification, we might call this proposal the Administration Prescription. It is compounded of numerous legislative items dealing with agricul-

ture, labor, social security, and so on; but its fundamental ingredient is the 875-page tax revision bill which is now before the Senate.

That bill would overhaul the whole Federal tax structure, from alpha to omega, in an effort to correct those sections of the present law which have been found by experience to be unwise or unjust, or to act as a deterrent upon the productive efforts of many individuals and economic groups, including business.

Tax reduction, *per se*, is not the real objective of this measure, since Federal taxes have already been cut twice so far this year. The real purpose of the pending legislation is to remove tax restraints on incentive; but the net effect, nevertheless, would be a further reduction in taxes for almost everybody—with one notable exception.

That exception is corporate enterprise; for this bill would re-enact and restore the high war-time corporate tax rate which expired, under the existing law, on April first. Thus its passage would increase the over-all taxes on business. At the same time, however, it does provide three important incentives as stimulants to business activity.

First, it would seek to increase the investment of venture capital by ameliorating, but not eliminating, the double taxation of dividends. Second, it would seek to increase productive efficiency by encouraging industry to replace obsolete tools and machines, even though they have not been worn out nor fully depreciated. And third, it would seek to encourage business of every size to expend greater effort on industrial research.

Those, then, are the simple facts of the case; and considering the length and complexity of the measure, there has been surprisingly little controversy regarding the great bulk of its provisions. No one, so far as I know, objects to the sections which liberalize medical deductions and provide tax relief for farmers, working mothers, young people, and many other such groups. No one has taken serious umbrage, moreover, at the provisions which increase the corporate tax burden. But in two respects the bill has provoked opposition so intense that Washington wags are calling it "The Keynes Mutiny."

This outcry is directed almost entirely at two alleged errors in the Administration prescription: one of omission, the other of commission. On the side of omission, opponents claim that the bill fails to grant adequate tax relief to consumers. On the side of commission, they protest that it provides unnecessary relief to producers in the field of business.

To remedy this situation, they propose on the

one hand to increase personal income tax exemptions. On the other hand, they would strike out of the bill one or more of the incentives which it offers to business.

So there we have what may conveniently be labeled "The Opposition prescription;" and the authors of it have their own diagnosis of our present economic difficulties. They say we are suffering from a lack of consumer purchasing power.

Now in passing we should note, I think, that this diagnosis itself may be open to question. Certainly it appears to be a considerable oversimplification of the facts; for the facts are that when business began to slump off, towards the end of the Korean conflict, purchasing power in this country was at the highest levels ever recorded anywhere on earth. It is also true, I am told, that every recession in history has begun when purchasing power stood at a peak. So in the face of these facts, it would be difficult to demonstrate that the recent economic decline was caused by any lack of consumer spending power.

Nevertheless, all of us will agree, I am sure, that an increase in real purchasing power would be highly desirable and of great benefit to our whole economy; so let's have it by all means. The question is: How do we get it?

Well, suppose we examine the two proposals advanced by the opposition. The first would increase personal exemptions, thus reducing the taxes of all individuals and relieving many of them from the necessity of paying any Federal income levy at all. This, it is argued, would place more money in the hands of consumers, who would therefore buy more goods and services. To meet this increased demand, business in turn would have to produce more. This would lead to increased employment, resulting in a further increase in purchasing power; and so our whole economy would start spiralling upwards to the lasting benefit of everybody.

All of which is wonderful—if true. As a businessman, I am naturally prejudiced in favor of any prescription which promises to increase our sales and enlarge our markets. As an individual who has two daughters in college, I would also welcome an increase in my personal tax exemptions; for I yield to no man in my desire to pay taxes—lower taxes, that is. So it is with considerable reluctance that I bring myself to suggest that we examine this plan a little further before we buy it.

But when we talk about purchasing power, we are talking, of course, about the sum total of the buying power of all our individual citizens, our businessmen, our institutions and our government agencies. Now, what happens if we

take a couple of billion dollars away from the Federal Government and put it in the hands of individual consumers? The individuals have two billions more to spend; but the Government, which is also a consumer—and I may add a spender—has two billions less to spend.

Has our total purchasing power increased? Not by so much as ten cents' worth. But, it is argued, the Government doesn't have to cut its spending at all. All it has to do is to print up two billion dollars' worth of bonds, and then go merrily on, buying at the same old rate as before.

And there, in truth, is what the authors of the Opposition prescription are really proposing—another great program of deficit spending, and another great whirl of inflation. Presumably this proposal would increase by two billions the number of dollars which we have in our national pocket; but, if so, it would also diminish proportionally, the purchasing power of each of those dollars. So, in the end, we should be right back where we started.

Ladies and gentlemen, I shall not argue here the question of inflation. There are a number of patriotic Americans who sincerely believe in deficit spending as a cureall for every economic ill. However, we should note, I think, that the same course is being urged upon us in more dubious quarters.

Recently, the Communist Party officially announced its new party line, and publicly disclosed its present aims and purposes. Third on the list of goals which it seeks is the scrapping of the Administration's economic program and the substitution of a policy of continuing inflation. That, then, is the course which is being prescribed for us by those who are openly and avowedly dedicated to the destruction of our American economic system.

In contrast to this advice, it might be well to recall a word of counsel from the Sermon on the Mount which says: "Enter ye in at the strait gate; for wide is the gate, and broad is the way, that leadeth to destruction."

The choice, I think, is clear.

And now let us look at the second part of the Opposition prescription — the proposal to strike out the tax incentives designed to benefit business. The authors of this proposal argue that we are already able to produce much more than we can sell; and that it would be useless to expand our plants and facilities any further at this time. What we need, they say, is more consumption, not more production. Therefore, they urge that the tax benefits proposed for productive enterprise should be given to consumers instead.

Here again, this all sounds so convincing

that it seems almost a shame to subject it to the cruel scrutiny of reason. But there is one little flaw in that argument that we simply cannot afford to overlook; and that is the fact that business, itself, is probably the largest single consumer in our whole economy.

For example, United States Steel, as a corporation, buys almost exactly as much in goods and services each year as do all of its 300,000 employees put together; and most businesses spend much more than their employees. So if we add to the buying power of individuals by subtracting exactly the same amount from the buying power of business, we have increased not a whit the total purchasing power of the nation.

How, then, can we get more money into the hands of consumers without taking it away from other consumers and without diminishing the buying power of the money itself?

Study that problem as you will, and I think you will find that there is only one way to solve it—by increasing the earning power of our people. But what a man earns can only be paid out of the value of what he produces. So if we would increase his earning power, we must first increase his productive power. And the only way to do that, in any substantial degree, at least, is to provide him with better, more efficient tools.

Such tools are available, but the trouble is that under our present tax laws, many companies cannot afford to junk their older, less efficient facilities until they have been worn out. So the need here is for wise and proper tax incentives which will encourage the widespread use of newly developed automatic machines which enable a man to produce two or three times as much, perhaps, as he could have turned out by older methods a few years ago.

These machines, if employed extensively throughout industry, would act as a kind of triple-barreled stimulant to our entire economy: first, by providing jobs for the men who make them; second, by increasing enormously the earning power of the men who use them; and third, by sharply reducing production costs. Thus consumers would not only have more dollars to spend, but each dollar would buy more, or better, goods.

But that device, alone, is not enough: for if, through this process, one man is enabled to perform the work of two, what then will become of the other man?

The answer to that, of course, is that he would be out of a job and out of luck if it were not for the enormous ability of American industry to improve existing products, and to create entirely new products which never ex-

isted before in any form. It is this inexhaustible inventive ingenuity above all else, I think, which has enabled our nation, throughout its history, to minimize technological unemployment, to support a constantly growing economy, and to enjoy an ever-rising standard of living.

The basic essential here is research; but research at best is a costly and uncertain gamble. Of the money poured into it, only one dollar in ten or twenty, or even a hundred, perhaps, will ever pay off in the market place; and it is often more difficult to pick a winner in the laboratory than it is at the Kentucky Derby. That is why the great burden of research has been borne chiefly by our larger or more profitable enterprises; and why research incentives are so important especially to smaller businesses.

But even this is not the complete solution to our problem, for research itself is merely the beginning. The only thing it really produces is knowledge; and before that knowledge can be transformed into new jobs and new products, someone must supply the money with which to build a factory, to buy the necessary tools and raw materials, and to advertise and market the product.

So the transmutation of new ideas into new products can occur only where there is a ready supply of venture capital—and the word to emphasize in that sentence is “venture,” for there is no assurance that the product will sell or that the venture will succeed. Yet it is upon this process of research and investment that our rising prosperity must always depend. That is the kind of industrial expansion that America can never afford to be without at any time. We must have it today, tomorrow and every day—in war and in peace, in good times and in bad. It is the life blood of our whole economy.

And there, I think, we have the final and conclusive answer to our question. How do we increase the earning power and the buying power of our people? By stimulating the replacement of inefficient, labor-wasting tools and machines; by broadening industrial research; and by encouraging a constant flow of venture capital.

But these, of course, are the very things for which the Administration prescription seeks to provide incentives. These are the exact ingredients which the Opposition prescription would eliminate, in whole or in part. They are, in fact, the self-same benefits which we hear reviled as “the trickle-down theory,” and denounced as “handouts to the rich.”

Ladies and gentlemen, there was once a farmer whose only possession was a fine and productive cow. But one day he said to himself;

“I have too much milk, and what I really need is meat.” So he butchered the cow and ate the meat—and then he starved to death.

Personally I question the sagacity of those who would butcher our productive cow. Rather, I am impressed by the wisdom of the old Biblical law which says: “Thou shalt not muzzle the ox when he treadeth out the corn.” It is found in Deuteronomy, I think, and it seems to me to be just as valid today as it was when it was written.

But there are, of course, contemporary authorities which might also be cited. Recently I ran across a lecture which was given by Professor Sumner H. Slichter, at Radcliffe College in 1942. He was discussing “The World of Tomorrow” and some of the views he expressed concerning our present tax structure surprised me considerably, coming as they did from a noted Harvard economist. It is said that the devil may quote scripture, but it is not always that a businessman can quote Dr. Slichter with impunity. What he said was this:

“The tax history of the United States in recent years has been fairly sensational. A visitor from Mars would suspect that a Communist fifth columnist was writing the laws for the purpose of making private enterprise unworkable. I am not complaining,” he said, “about the general level of taxes. Rather, I am complaining of the extraordinary way in which taxes have been modified to bear heavily on any enterprise or individual who displays daring, or who backs an innovation or experiment, especially an experiment which is pretty certain to experience losses for a few years. If the community really wishes expansion, it must be prepared to overhaul very drastically the present tax system—not necessarily by shifting the burden between income brackets, but by altering the way in which taxes affect the attractiveness of risky ventures.”

In presenting this statement from Dr. Slichter, let me repeat that it was made twelve years ago and, therefore, could not have been intended to apply directly to our present-day tax controversy. But if I understand his complaint correctly, it would seem to me that the evils against which he protests have grown rather than diminished since that time, and are exactly those which the pending tax bill seeks to lessen in its sections applying to business.

So in analyzing the new tax measure, let us remember that it was not drafted and passed in the House of Representatives by men who were selfishly interested in helping the idle rich or in aiding a handful of big corporations. It was written and supported by men who must face the voters again next fall, and whose last, best hope of re-election lies in increased em-

ployment, a prosperous community and a contented constituency. These men have staked their political future on their belief that the bill which they passed will create the economic conditions which favor their return to office.

But, ladies and gentlemen, the real and vital issue which lies at the heart of this controversy is not just a question of taxes. Our economy is strong and resilient. It has survived bad tax laws before, and will doubtless do so again—for after all, were there ever any good ones? But no true democracy can long survive, I believe, if it ever falls prey to class hatred and group prejudice, if consumer is pitted against producer, worker against investor, poor against rich, housewife against farmer — American against American.

The body economic of America is composed of 160 million individual human cells, many of which perform different tasks, but all of which are part and parcel of the same economic structure. Now, if some of these cells start malignantly to feed upon others, so that one group suddenly thrives and multiplies while another languishes and disappears, then indeed is our national economy stricken with a dread disease, which none of us can survive; for even a cancer destroys itself when it kills the body in which it lives.

And that is why I am more than a little disturbed tonight by what seems to me to be a conscious effort on the part of our self-appointed medicine men to appeal to greed and to inject class hatred into this vital discussion. They are determined, apparently, to dismember our economy by dividing us into warring groups in the hope that we shall permit blind anger to suffocate our reason.

But before we allow ourselves to succumb to that kind of economic poison, I would like to suggest that we try a little experiment right here in this room. Suppose I were to ask all the producers in this audience to go to one corner, all the consumers to go to another, and all the investors to go to a third. To which corner would you go? And how could you possibly comply with that request without developing a kind of three-way case of schizophrenia?

All of us, of course, are producers of goods or services. All of us are also consumers. And all of us, too, I suppose, are investors—for an investor, remember, is anyone and everyone who has put money in a bank, or in a savings bond, or a life insurance policy, or a pension fund, or a share of stock, or in a business or profession of his own.

And so will it be always in any ordinary group of people of working age, whether we find them on the street corner, in a bus, at the

ball park, or here on the Atlantic City boardwalk. The truth is that under our economic system the consumer, the producer and the investor are not three separate individuals. They are one and the same person, wearing three different hats at one and the same time. Their interests can never conflict. They must prosper together, or not at all.

So the next time we hear someone denouncing business incentives as a "give-away program for the rich," it might be wise to stop and ask ourselves just what his motives are. What is he trying to sell?

Glance under the flap of his medicine tent, my friends, and you'll find, I suspect, that it's snake oil.

And as for the so-called "trickle-down theory," let's look at the fact for a moment. The phrase suggests that the pending tax bill would give rich benefits to those at the top of our economic pyramid in the hope that some of this money would trickle down to the poor unfortunates below, like crumbs falling from a banquet table. But that, of course, is the exact opposite of the truth.

The truth is that the new tax measure affords no benefits whatever to those at the top until they, themselves, have poured their own money in at the base of our economic structure in the hope that, like water rising from a spring, it will flow up from below and come back to them.

Thus after an enterprise has risked its money in research, or after it has bought and installed new and more efficient tools of production, then, and only then, is it accorded favorable tax treatment on the funds it has expended for these purposes. Without making such expenditures, it gets no tax advantage from the bill at all.

And so it is also with the provisions relating to dividends. To get any tax relief under this section of the bill, the taxpayer must first have dividends. To get dividends, however, he must first invest his savings in corporate enterprise. But before a corporation can pay any dividends, it must do two things: First, it must spend the capital it gets from the investor to construct plants, to buy machines and tools and materials, and to hire workers to use these facilities. Second, it must market its product at a profit; and it can only do this if the product itself is something which benefits the consumer—something he wants and is willing to buy.

Then and only then does the investor have any prospect of getting a dividend. He is the last man in the whole, long economic chain to receive any reward at all from his investment. All the others must get theirs first—the builders of the plants and machines, the suppliers of

the raw materials, the workers who turn out the finished product, and the consumers who buy it; and when, if ever, a dividend check does finally trickle up to the investor, by the slow and meager process of osmosis, it usually amounts to only a few cents on each dollar that he has risked in the venture.

So if we are to apply to the Administration program a name which accurately and truthfully describes the processes which it would set in motion, we must call it, I think, "the trickle-up prescription."

These, then, are the real facts of the controversy as I see them, but I shall argue them no further. In my role as a kind of Public Defender of the patient, I shall rest my case; but in doing so, I should like to address one final word of caution to the jury:

The economic health of America is one of our most priceless national possessions. It will be profoundly affected, for better or worse, by the decision in this case. Since we live in a democracy, the responsibility for that decision

rests upon each one of us — upon every citizen of this country.

Before us are two proposed courses of action which are sharply in conflict, one with the other. We cannot afford to choose the wrong course. Neither can we afford to be guided by personal ambition or narrow self-interest. We must weigh each proposal on its merits, asking ourselves this question: Not "what will it do for me?" but "what will it do for America?"

That is the issue which faces us; and the decision is up to you. Which prescription will you choose? You're the doctor!

(Applause)

PRESIDENT DECKER: I think we all enjoyed the presentation of the brief by the General Counsel. I hope that we read it carefully and think about it seriously.

This concludes the General Session of the 188th year of The Medical Society of New Jersey. (Applause)

(The meeting was then adjourned at 10 p.m.)

GENERAL SESSION II (Banquet)

Tuesday Evening, May 17, 1954

The speakers' section of the banquet convened at 8:50 p.m. at Haddon Hall, Dr. Reuben L. Sharp, Toastmaster.

DR. SHARP: Ladies and Gentlemen: Dr. Bowen, Chairman of Reference Committee "E," reported on a certain Sultan who didn't know where to start. I thought I was in the same position until Mrs. Madden came to my rescue. Now I know where I'm going to start. She also told me that she didn't do the thing that she did to our President. She carefully wrote down all he was to do and then added "Now you are on your own."

It gives me a great deal of pleasure to introduce to you the President of the Woman's Auxiliary, Mrs. Frank S. Forte. Unfortunately, her husband could not be here tonight. Mrs. Forte will bid you welcome. (Applause)

MRS. FRANK S. FORTE: And now I am on my own. Dr. Sharp, Dr. Decker, Mr. Meder, Members and Guests: It is my pleasure to bring greetings to you from the Woman's Auxiliary to The Medical Society of New Jersey and to welcome you to this dinner in honor of Dr. Henry B. Decker, President of The Medical Society of New Jersey.

This year we celebrate our twenty-seventh

anniversary, one hundred eighty-eight years of The Medical Society of New Jersey, and the hundredth birthday of Atlantic City.

The sincerity, ability and enthusiasm of the members of the county auxiliaries are an inspiration to a State President to keep striving to do her part.

I was told to make this short. In conclusion (Laughter), may I leave you with this thought in mind in reference to public relations: Public relations is always being stressed everywhere we go, and I like Dr. Kline's definition — he is from the A.M.A. His definition of public relations is this: To do good, to be good, and to tell the public about it. (Applause)

DR. SHARP: Thank you, Mrs. Forte.

And now I'd like to introduce Mrs. Paul E. Rauschenbach, President-Elect. (Applause) And my friend, Dr. Elton W. Lance, President-Elect. (Applause)

(Dr. Sharp then introduced the following: Mrs. Murray, Dr. Rauschenbach, Mrs. Lynch, Mary Chambers Sharp, Dr. and Mrs. Hewitt W. Smith, Dr. George H. Gildersleeve and Mrs. Gildersleeve, Dr. and Mrs. E. Tremain Bradley, Dr. and Mrs. John Carr, Dr. and Mrs. Theodore Fetter, Mr. Curry.)

DR. SHARP: Sometime ago, in fact it was at the last Board of Trustees' meeting in Trenton, Dr. Decker and I tangled and Harrold Murray said: "Why don't you fellows get together?" And Henry said: "Hell, we fight all the time." (Laughter) But let me tell you this: When we do, it never disturbs the peace and quiet south of the Rancocas. Dr. Murray. (Applause)

DR. HARROLD A. MURRAY: Dr. Sharp, Dr. Decker, Honored Guests, and Ladies and Gentlemen: This is the night that I waited for for a long, long time, in fact it is really about seven years. That occasion was at Rutgers and I had the opportunity of talking on, I guess it was, malnutrition, and Henry had the opportunity of introducing me, and what he did to me was terrific. I had taken some of my residents down, you know, and I was going to put on a big show, and he broke up the whole thing completely. He started off with everything I ever did in my life: He was the past-this, the past-that, the past-that, and I began to feel like there was never a guy that lived that's lost so many jobs as I did. (Laughter) So I'm trying to get back, see.

Well, today I have a great honor, really, and I wanted to say some really intimate things about Henry Decker, but I'm not on neutral ground here. Every man and woman in this house loves Henry Decker, so wouldn't I be a darn fool to say anything against him? So I'm not going to do that because I honestly believe, Henry, that sometime or other, at another occasion I will have an opportunity, that I am not going to take tonight, to really get back at you for that introduction at Rutgers.

You know, over the years—and it is very interesting to follow, I know Fred Quigley could verify this—there are all types of Presidents in our Medical Society and every one contributes something. I said, with a sigh of relief when I finished: "Isn't it a darn good thing they don't have to take me for another year?" So you see, everybody contributes, and Henry Decker has contributed with dignity, and with almost poetic grace he has served as President of our Society to the inspiration of every man in it. He really is a highly cultured gentleman, which probably is the most important thing in life. And it has been a great honor and privilege to have sat with him when he got away from the Rancocas and came back to Trenton and really deliberated with the members of the Board of Trustees. In my term of office last year he was really a tower of strength to me, and even in our last meeting of the Board of Trustees he really voted on

our side, didn't he, Mark? Which is something. It was only three we lost, but once in a while it is nice to lose, isn't it, Henry?

Traditionally each year, over the many years of our great organization, it has been the custom of the immediate Past-President to present a memento to the President as he leaves office. I don't think Henry needs any visual aid to realize the great opportunities that he had and fulfilled, the great honor and thrill that it was to be President of The Medical Society of New Jersey. He is going to treasure that for many, many years. But this little key will probably do something more than that. It will open our hearts to him anytime he wants to creep in there, and we will be very glad and happy to have his advice.

Henry, I want to give you this key, and with it goes my love and affection, and I know every member in this room feels the same way as I do. I hope that you will live many, many years and that it will adorn that very beautiful vest and chain that you have, and that you will go through with your great activities and be very happy with your very wonderful accomplishments that you have made this year.

(The audience arose and applauded as the key was presented to Dr. Decker.)

PRESIDENT DECKER: Mr. Toastmaster, Dr. Murray, Mr. Meder, Members and Guests of The Medical Society of New Jersey: I deeply appreciate this key. It is a symbol. You will recall in the ancient Greek mythology that Prometheus was supposed to have set up the earth, then taken some mud or dirt from a stream and molded it into a man—made him breathe, made him look so that he could see upward; then went to Heaven and brought fire down from the sun so that he could live and control things. Then Prometheus went back to the gods and stole something else, for which they punished him terribly. That something else was truth and wisdom.

It is with these keys that we search for such truth and wisdom amongst the hearts of men, and we very frequently find it.

Now, I have accounted for my stewardship in the proper places and at the proper times. In a few moments I will be as useful to the Medical Society as yesterday's newspaper or last year's bird nest. I will be a Past-President.

I have completely enjoyed this year of service. I have given very, very little; accomplished almost nothing, when the scores are added up. But I have established two records. One record occurred in our first Trustees' meeting after reorganization, in which my President's report took up some four hours. They tell me that it was the longest one in the history of the Society.

And this morning I think that I am the only President of the Society to have my decisions in the chair questioned by individuals who have looked too much at television during the past few weeks (laughter), and found out that the point of order is a common word. Fortunately, the House sustained me, but by the time I got through I felt as I once felt with a forty-pound pack and a seven-pound rifle and a twenty-mile march.

I have one other duty to do, Dr. Sharp tells me, which is one of the most pleasant ones that I shall ever do in this Society. Back some years ago when the Camden County District Medical Society had its centennial meeting, we had several speakers; amongst others, the Dean of Rutgers University, who talked about the historical background of New Jersey. We enjoyed it very much. He told me that sometime he would like to prepare a talk on the first things that happened in this country, in New Jersey. So I have asked him to give such a talk. I know that you will enjoy it.

I have known Dean Meder for many years. Our first meeting was a dispute about his ability to establish a curriculum and my ability to advise my daughter. We both lost the dispute because she decided differently.

May I introduce Dean Meder. (Applause)

DEAN ALBERT E. MEDER: Dr. Decker, Mr. Toastmaster, Ladies and Gentlemen; I count it a great honor to be asked to come here tonight and speak to you on the occasion of this dinner in honor of my friend, Dr. Henry Decker.

It is true that he suggested to me that I talk to you on the subject of first things in New Jersey—the first road up in North Jersey, the first river, the Rancocas, and other first things. However, I must confess that the press of my duties has made it quite impossible for me to develop that theme, and I am sorry to disappoint him, but I will not be speaking along those lines.

I notice by the program that this is the 188th meeting of The Medical Society of New Jersey. There surely are very few organizations in our State as old or older. It happens I represent one the same age; we will be having the 188th Commencement of Rutgers University, once Queens College, this June; and to come to you from a contemporaneous organization gives me added pleasure. Of course, the Proprietors of East and West Jersey are older. They are, I think, the oldest corporations in existence today anywhere in the world.

The subject that was announced for my talk—"Liberty and Prosperity"—is only a spring-

board from which I wish to take off to discuss something else. The reason for this has been alluded to already. When Dr. Decker asked me if I would accept the honor of appearing before you this evening, he suggested that, while he would leave the subject entirely up to me, I might talk about something that had New Jersey implications since I was talking to The Medical Society of New Jersey.

Sometime later a request came for a topic for the program. Well, you know, such requests always arrive before the speaker has begun to prepare his talk and consequently all the poor fellow can do is to choose some title which gives him plenty of latitude and hope that when he gets around to preparing the talk he can relate it in some fashion to the title he has given.

Remembering what Dr. Decker had said about New Jersey, I chose as the title the motto of the State, "Liberty and Prosperity" (I thought that would give me plenty of latitude) and let it go at that.

I shall, therefore, take off from the State motto and with, I think, little effort I will arrive at the topic on which I really wish to speak, which I will reveal in a few moments.

Having chosen the State motto as the title of my talk, it occurred to me to compare the motto of New Jersey with those of other states. This is a piece of research which is very simple. All you need is the Information Please Almanac or some similar source. Anyone can then find out for himself what I found and what you would indeed suspect; namely, that the forty-eight states have a tremendous variety of mottoes—some significant, some almost meaningless; some in the nature of slogans or advertisements: "Cross Roads of America," for instance; some descriptive. Twenty-two are in English, twenty-one in Latin, and one each in Greek, Italian, Spanish, French, and Indian. This latter, by the way, the motto of the State of Washington, is interpreted to mean "By and By." Why this is a suitable motto for any state, even for the State of Washington, I simply can't understand.

At the other extreme we have such rhetorical phrases as the motto of North Dakota: "Liberty and Union, One and Inseparable, Now and Forever," which seems to have been cribbed from Daniel Webster, if I remember correctly. And the motto of Iowa: "Our Liberties We Prize and Our Rights We Will Maintain." The motto of Texas, believe it or not, is "Friendship;" that of Utah, "Industry;" that of Rhode Island, "Hope." It seems you can have just about anything you want in these United States. For the motto of Tennes-

see is "Agriculture, Commerce;" and that of Nebraska, "Equality Before The Law."

When compared with these mottoes of some of our sister states, that of New Jersey seems very calm and intelligent, even though our neighbor, Delaware, has chosen "Liberty and Independence" rather than "Liberty and Prosperity." That seems slightly redundant somehow. And Pennsylvania goes one better by demanding "Virtue, Liberty and Independence." (Laughter)

All of these mottoes, of course, in one way or another breathe the spirit of America—a devotion to the spirit of freedom, to the unalienable rights of life, liberty and the pursuit of happiness, to freedom of thought, freedom of speech, freedom of action, freedom of religion.

Important as these ideals are, I do not propose to deliver an oration in praise of liberty, in defense of freedom, or one devoted to eulogizing our American ideals. I don't even propose to show how for doctors of medicine liberty and prosperity are important. Instead I would like to assume as a starting point that liberty and prosperity, along with all the other ideals we have mentioned, are desirable in themselves and that no defense or proof that we should cherish them is necessary.

I should also like to assert, as a basis for our discussion, that our liberties depend upon education for, as Edmund Burke said over 150 years ago: "What is liberty without wisdom and without virtue? It is the greatest of all possible evils, for it is folly, vice and madness without tuition or restraint." And as he said even earlier: "The people never give up their liberties except under some delusion." So also Mr. Justice Brandeis, 140 years later: "The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding."

Neither do I wish to address myself to a discussion of the encroachments being made on liberty today by men of more zeal than understanding. Whether they are well-meaning or not, I leave to you. I propose instead to discuss briefly something of the present state of education on which, as I see it, the preservation of our liberties and our prosperity largely depends.

What, then, is the state of education today? There are essentially two factors which we should consider: Those factors relating to the quality of education which is being offered today in our schools and colleges, and those factors relating to the quantity or amount of education demanded and the number of people to whom its benefits are to be made available.

As a matter of fact, these factors affect each

other materially. The classical statement of quality in education has long been a student at one end of the log and Mark Hopkins at the other. But if the number of students were so increased as to fill the log, even Mark Hopkins might have been put to it to continue education of the same quality.

There are today in some quarters complaints about the work of the schools. In my opinion, these complaints usually spring either from a failure to understand what the purpose of the school actually is or from a failure to understand the difference between the problems with which the schools of the mid-twentieth century must cope as compared with those faced by the schools a generation or two or three ago.

Let us remember, then, first of all that education for intelligent citizenship was the primary purpose in the establishment of the free public schools. Even George Washington said: "Promote them as an object of primary importance—institutions for the general diffusion of knowledge. In proportion as the structure of a government gives forth to public opinion, it is essential that public opinion be enlightened." American education is for the liberation of the individual, not for propaganda or for the regimentation of the people or even for the production of an educated class fitted for leadership or the staffing of the professions, important and essential as these latter objectives are.

As far as elementary education is concerned, there is no doubt whatever that today we know far more than was known fifty or one hundred years ago about how children grow and how children learn. The plain implication of this is that we know better how to teach them.

It is for this reason, for example, that the old-fashioned spelling bee—which had not completely passed from the scene even in my school days, and which we know was of great importance a generation or two earlier—is no longer one of the chief activities of the school nor, for that matter, one of the chief social events of the community. It has passed not because the schools wish to neglect the teaching of spelling but because there are better ways of doing it.

We hear a great deal of complaint even on college campuses that students cannot read, but it is also a fact that a tremendous amount of research has gone into the subject of the teaching of reading and that by applying the knowledge we have, we are doing a better job for tremendously more of the children than was the case years ago.

As a matter of fact, there have been instances in which precisely the same tests that were used

some eighty years ago have been given to school children of the present day, with the result that our present day school children have done at least as well and in most cases better on the so-called fundamentals than did their great-grandparents when the tests were first given.

Also we must never forget that today we have a great many more children in school for longer periods of time and a great deal more to teach them than was the case in the good old days.

I well remember a third grade teacher of mine who, whenever she did not know what to give us for homework, required that we write out the multiplication tables from one times one through twelve times twelve, forward and backward, as many times as happened to strike her fancy that day. I am not prepared to admit that this is the most appropriate way to teach a child to multiply, though as a mathematician I yield to no one in the importance of having children taught to multiply. Somehow I am inclined to prefer the kind of education that gets a sixth grader to do what a young friend of mine did within the past week — to spend all of his free time for a couple of days making himself a homemade telegraph set out of a few nails, a coil of wire and pieces cut from a tin can according to directions printed in the school textbook.

I will be the last to deny that a good deal of nonsense has been spoken and printed by educational theorists and educational hobby-riders, and a good deal of so-called educational literature is not worth the paper on which it is printed. But I remember, too, that education, as a subject for study and research, is very young, much less than a century old; and I remember, too, that a lot of what is published in older and allegedly more respectable fields like mathematics, if you will, or perhaps medicine, is also not always as profound as it might be.

However, I think people are pretty ready to admit that the elementary schools are in general doing a good job. For one thing, the children like to go, and their development is obvious. They start in the first grade unable to read, unable to write, unable to do arithmetic, ignorant of history, geography, science; and from year to year it becomes apparent that they do learn how to read, they can compute, they can write, and they know increasingly the ordinary facts about the world in which we live and the nation of which we are a part.

It is when we turn to secondary education, high schools, that we hear more grumbling. This, too, in my opinion, is largely a failure to understand the situation. Most of us still think

of the high school as a sort of classical college preparatory institution. I wonder, however, if we would really be willing to accept the educational ideas of those who were the leaders in secondary education when this was in large measure the ideal of the high school. For example, in 1892 a very important committee, known as The Committee of Ten, attempted to allocate and standardize the high school day. This committee saw no distinction between the educational needs of college-bound and non-college-bound students, although it did not actually expect that the public schools would really send very many on to college. The committee unanimously agreed on this, and I quote: "Every subject which is taught in the secondary school shall be taught in the same way to every pupil as long as he pursues it, no matter what the probable destination of the pupil may be or at what point his education is to cease." If you think this is fantastic I agree with you.

At the same time, President Charles W. Eliot of Harvard, who was Chairman of the Committee of Ten, announced that— and I quote from him: "The secondary schools, taken as a whole, do not exist for the purpose of preparing boys and girls for college. Their main function is to prepare for the duties of life that small proportion of children in the country, a proportion small in numbers but very important to the welfare of the nation, who show themselves able to profit by an education prolonged to the eighteenth year and whose parents are able to support them while they remain in school."

Well, whatever the secondary schools were in 1890, when only 350,000 pupils enrolled, they certainly are not that today. Over seven million students are enrolled in our high schools now, an increase in attendance of 1900 per cent in the past sixty years. The schools now state that their obligation is to all the children of all the people.

I think it is obvious that when any human institution, school or anything else, is called upon within two generations to increase its service by 1900 per cent, there are bound to be growing pains.

It should be remembered, too, that a very substantial part of this increase in secondary school enrollment took place within the last twenty or twenty-five years, largely as a consequence of the depression which removed from the labor market many young people who formerly left school to engage in gainful occupations. The secondary schools had to make a tremendous adjustment in an exceedingly limited time, and the wonder is not that they

failed in some respects but that they succeeded so remarkably well as they did.

As we look at the secondary school today, we are sometimes inclined to think that once upon a time when we were there it did a much better job. But this is simply not borne out by the facts. As is usually the case, the good old days were not so good as hindsight makes them appear.

I shall give three quotations on this point, for which I am indebted to my good friend, Dr. Harold A. Odell, the Principal of Montclair High School. The first is from the Principal of the Cleveland Central High School in 1862—that was certainly in the good old days—who complained to the Cleveland Board of Education that over one-quarter of the freshman class in his high school were not capable of doing high school work. "The number enrolled during the last year was 212" — this was in the City of Cleveland—"a larger number than ever before in the history of the school. This large enrollment," he says, "was caused mainly by the large number, 90, admitted from the grammar schools. Of the 90 pupils at least 25 ought not to have been admitted. They formed during the year a class of incapables, and at this time those of them who remain in the school are just where they were a year ago, having failed, some of them, in all, most of them in two-thirds of their studies."

In 1866 the Principal of the Providence, Rhode Island, High School included in his annual report these sentences: "I would also recommend additional tests in the examinations of our schools that we may ascertain not only what the pupils know but what they can do. It is not an uncommon occurrence to meet with scholars who have a satisfactory examination in many of the higher branches of study, to be ignorant of the simplest elements of knowledge. They violate the plainest rules of grammar and fail entirely in the correct use of fractions. Penmanship in particular ought to receive more attention." The good old days were not so good.

And finally note that "in 1897-98 only 14 per cent of the total enrollment in all public and private schools were preparing for college, which explodes the myth that the high school enrollment of 50 years ago was a homogeneous one composed only of college-bound students."

It is obvious, I think, that when high schools enroll, as they do today, 80 per cent of the entire age group from 14 to 18, they have both a more challenging and a more difficult task than when they enrolled only some seven per cent and could encourage many of those, if unsuccessful, to drop out of school — something

which perhaps fortunately, perhaps unfortunately, cannot be done today.

Today's high school is endeavoring to tailor each student's program to fit his abilities and his needs, to extend further individualization of instruction, to provide ability grouping and better counselling services. There is increased emphasis on the teaching of democratic citizenship. Many high schools have what has been called a two-pronged format: good citizenship and good scholarship. While recognizing, as they must, that one of their primary functions is to prepare pupils who wish to continue their education for admission to higher institutions, they also recognize that they have a duty to that portion of the high school student body, approximately 80 per cent, who will not go on to college or university. Secondary school leaders assert, and I think with real justice, that it cannot be maintained that the education of either the 20 per cent who go on to college or the 80 per cent who don't, is of greater importance.

What about higher education? Are our colleges and universities static or are they, too, concerned with similar problems? The answer is that they certainly are. Anyone who has looked even casually at the literature of higher education in the last decade has been struck by the use of a totally new term—general education. If he undertook to try to find out what this term meant, he had a much harder job because just about every writer had a different idea of what he meant by the term. However, what it indicates is that the colleges, too, are no longer content to turn out students who had either spent all their time studying some one subject or who have had the kind of program described by the late Dean Hawkes of Columbia College, as a freshman year followed by three sophomore years. They have been trying to bring coherence into the college curriculum.

I cannot take time, and you would not wish me to if I wanted to, to describe the various programs by which the different colleges have attempted to provide for coherent non-specialized study. It is sufficient, I think, to call attention to the fact that this is one of the major ferments in higher education at the present time.

Related to it and indeed somewhat similar has been a movement to remove from professional education a large amount of specialized and technical detail and put the stress increasingly on a genuine understanding of the fundamentals of the field. Thus, the engineering schools no longer find it necessary to offer a great variety of technical and specialized courses in mechanical engineering, in electrical engineering, in structural engineering, in this and

that. Instead, the common core for all varieties of engineers is much more emphasized than was the case even a decade ago, and there is increasing recognition that the engineer must be an educated man as well as an accomplished technician. That same spirit is in education for all the professions.

In the liberal arts college, too, it is becoming increasingly recognized that the purpose of specialization is not the accumulation of a vast collection of facts, but, rather, the development of a resourcefulness and competence which will permit the college graduate to apply his education to the solution of problems which have not yet even arisen.

It cannot be foreseen in any form of higher education, liberal or professional, what specific information of facts the student will have need to use in his later personal or professional life. What can be foreseen, however, is that if he enters any vocation in which he has to use his brains at all, he will find it necessary to assemble facts for himself, to interpret them, to dominate this body of knowledge which he has accumulated, to foresee its implications and to act upon these implications. It is to give him an experience in intellectual mastery of this sort that colleges require majors, not that he may, when he receives his bachelor's diploma, be a person whose mind has been stored with sundry facts about English literature, German philosophy, higher mathematics, inorganic or organic or physical chemistry or Latin or Greek authors.

Moreover, there is a very encouraging sign in the fact that college and high school people have been coming together increasingly in recent years to improve the articulation of these two important levels of education. Until very recently, indeed, the secondary schools have developed their programs without much reference to the colleges except to complain, with some frequency, of the domination of college entrance requirements, which, according to many leaders in secondary education, have prevented them from doing that which they knew was best for the multitudes of students under their charge who were not going on to college. And similarly, college authorities have prepared their curricula on the assumption that they knew exactly what they were getting from the high schools and that they might begin their work without any reference to the previous educational experiences of the college freshmen. Happily this situation is changing.

Recently the Fund for the Advancement of Education, one of the Ford Foundation agencies, has conducted four separate and distinct studies in this general field. One was a study

involving three distinguished independent preparatory schools—Andover, Exeter and Lawrenceville—and three equally distinguished independent colleges—Harvard, Princeton and Yale. I put all of those in alphabetical order. The purpose of this study was to determine whether even these three schools, on the one hand, and these colleges on the other, which have traditionally and historically and practically had an exceedingly close relationship one with the other, were providing a properly articulated course of study. The findings, which are published in a most interesting book entitled "General Education in School and College," were that the articulation was not good; that much of the college freshman year was a duplication of what had been done in secondary school and that in many cases the combined program could profitably be reduced from eight years to seven. Obviously such a reorganization would have an important effect upon later education for the professions, particularly for your profession where the length of time of preparation is a serious factor.

At the same time, another study, with the elaborate name of The School and College Study of Admission with Advanced Standing, involving a group of twenty-seven public and private schools, mostly large city schools, and some twelve or fifteen liberal arts colleges, including, however, one engineering college, has been looking into the possibility of encouraging schools to offer for their better students advanced courses essentially on the freshman college level for which the colleges would give advanced credit toward the college degree. A large number of committees have prepared syllabi of college level courses which might be offered in the high schools and these syllabi have been agreed upon by the participating colleges as satisfactory. As I have indicated, there are at this time some twenty-seven schools involved in the experiment, which have actually been teaching these college level courses to their high school students this year, and this month or next the students in these courses will take a set of examinations specially prepared by committees representing the schools and colleges, to determine whether this work which they have done in high school is worthy of credit toward a college degree.

There is every reason to believe that the College Entrance Examination Board will pick up these studies at this point and offer examinations on an advanced level for students who wish to prove that they have in high school learned material which would normally be included in the college curricula and through these examinations obtain either exemption

from repeating the duplicated work or even college credit for the work they did in the secondary school.

Another experiment has involved the admission to college of a considerable group of high school students who have completed only the first two years of high school. In general, these students have done as satisfactory work in college as those who completed the full four-year high school course. However, the obvious inference that the last two years of high school are unnecessary is fallacious, for reasons which I will not take time to discuss.

Personally, I believe that this experiment is of much less significance than the other two and I will not go into it any further. I also will not describe the fourth experiment except to say that it was an investigation into articulation cooperatively between the public schools of Portland, Oregon and Reed College.

Here in New Jersey for six years we have had a committee appointed by the State Commissioner of Education, representing both the schools and the colleges, to see what can be done to improve articulation in this State. This committee has had subcommittees at work studying the program in English, mathematics and languages, with some very good results. It has promoted a program of inter-visitation of school and college, and actually has gotten some college professors out to see what a modern high school is—professors who hadn't set foot in a high school from the day they got their high school diploma until this program got under way. It is making a study of the amount of duplication of high school and college work that goes on in the run-of-the-mill New Jersey high school and the New Jersey colleges and it has promoted acquaintance and understanding of one group with the other.

I should also like to mention briefly one other movement in higher education which I think is of very real significance and which has some very specific applicability to you as members of a medical association. I refer to the development of new technics in the accreditation of colleges and universities.

Almost everyone has heard of an accredited college and thinks he knows what is meant by this. He regards it as tantamount to a stamp of approval such as that placed upon electrical equipment by the Underwriters Laboratories or upon household equipment by the Good Housekeeping Institute. And in a sense he is correct. But in what sense is an accredited college approved?

Until about ten or fifteen years ago, both secondary schools and colleges, to be accredited, had to meet certain hurdles. There had to

be so much endowment, so many books in the library, such and such a ratio between the number of teachers and the number of students, so many Ph.D's on the faculty, so many cubic feet of classroom per student; the teaching load had to fall within certain quantitative limits and so on. The result was that institutions which wished to do so could often meet the letter of the requirements and fail completely to meet the spirit.

Moreover, colleges and universities were subjected to the standards of a great many different accrediting agencies; that is, one group to accredit liberal arts colleges, another the engineering school, another the law school, another the school of medicine, another the college of pharmacy, another the school of journalism, and so on. This was getting to the point where the colleges were in the position of having outside organizations effectively take over the management and control of the educational experience. Now this is being changed and I am pleased to say that in our own area, the Middle Atlantic States, we have made more progress than any other part of the country.

Now a school or college which wishes to be accredited submits a detailed account of its organization, its program, its operations, its financial resources, its student life program—indeed a report covering all aspects of institutional life. Most important in this report is the statement of the objectives and purposes of the institution and its indication, through whatever evidence it can compile, of the extent to which it is effective in translating these purposes and objectives into actual educational experience. All of the various agencies interested in the maintenance of educational standards combine to study this report and to send a visiting team of experts from outside the institution to spend several days on the campus checking statements made in the report, probing into the activities of the institution, catching the spirit of the campus, by whatever means commend themselves to the team. It is positively astonishing how such a team can in a very few days form an opinion of the effectiveness of an institution, which is even more accurate than that held by the officials of the institution itself.

This emphasis upon the formulation of clearcut and well-defined objectives, upon the program and technics established for their attainment, and upon the outcomes of this program is one of the most promising devices which has yet been discovered for maintaining the integrity of workmanship of the institutions, of the secondary and higher education

of our country. It permits diversity of institutions, but it holds them all to the maintenance of honest and honorable standards. It is a sort of Better Business Bureau for high schools and colleges, which serves to guarantee to the people that their educational institutions are truly fulfilling the trust placed upon them. As I have said earlier, this trust is nothing less than the maintenance of our democracy itself.

It is well that these forward movements in education have taken place, for in the next fifteen years education will face a crisis unparalleled in American history. Reduced to the simplest possible terms, this crisis will consist of too many students, too few teachers, too few buildings, and too little money.

You presumably know what has happened to the birth rate in the United States. In the years from 1938 to 1940, approximately two and one-half million babies were born annually in the United States. Beginning in 1940 the birth rate began to climb. It rose 17 per cent in the two years from 1940 to 1942. After falling off a little bit for the next two years, it then increased from 1945 to 1947, another two-year period, by 34 per cent, and it has not fallen appreciably since. In other words, births in the United States now number around 3,900,000 annually. Ten years ago there were one million less, 2,900,000; twenty years ago, one and one-half million less per year.

Making due allowance for those comparatively few who do not survive, those of us in education know that between five and six years after birth children find their way into kindergartens and elementary schools; approximately fourteen years after birth they find their way into the secondary or high schools; in eighteen years after birth they find their way into college.

These statistics mean that we have already had to provide in New Jersey for tremendously increased enrollments in the elementary schools, and in a very few years will have to provide for similar increases in the high schools. While the elementary schools continue to carry the loads they are now carrying, the effect is obviously cumulative.

Perhaps one of the clearest ways of describing this crisis is to put it in terms of the annual need for new teachers. It is estimated by our State Department of Education that from now until 1960 we shall need something like 3000 new teachers in our public schools every year; 2000 of them to replace teachers who change to other positions or who retire or drop out of the profession; but 1000 of them brand new entrants to the profession. That means a thou-

sand this year and a thousand more next year and a thousand more the year after that, right up until 1960. By 1960 we shall have to provide for approximately 200,000 more pupils in the public schools than we have this year.

I was greatly tempted to enlarge on that and point out what it would mean in terms of classrooms and maintenance funds as in teachers, but I think if you can just imagine that army of one thousand new people needed year after year until 1960, you will get a pretty vivid picture of what we are up against. I may say the thousand per year are not in sight.

The crisis in higher education is of the same nature. The only difference is that it will come upon us later. At the present time New Jersey has 218,000 young people of college age. By 1960 there will be 251,000; that's 15 per cent greater. By 1970 there will be more than 380,000, an increase over 1953 of 75 per cent. For every four New Jersey boys and girls in college anywhere today, sixteen years hence there will be seven, assuming that no more proportionately go than are now going. However, the percentage of the population attending college has been increasing steadily for the past fifty or sixty years. The increase is approximately four-tenths of one per cent of the eligible age group annually.

From all of this, it is clear that the problem confronting higher education is nothing short of staggering. Furthermore, before the war, New Jersey sent 84 out of every 10,000 of its young people to college, whereas the average in the United States was 99—in other words, we weren't sending as many as typically was the case in the nation—and 34 of those attended college within the State, whereas typically 77 of the 99 attended college within the State. So the rate of increase in New Jersey is bound to be greater than this four-tenths of one per cent which is nationwide. In 1970 there will be in New Jersey 175 per cent of the present number of young people of college age, 183 per cent of the number that there will be in 1957.

If you think that we can look with equanimity on the task of finding professors to teach all those people, I assure you we do not. Those professors ought to be in the graduate schools right now, and they aren't there, for another very good statistical reason; the population that is now in school and college is the product of the years of very low birth rate which we had during the depression.

Well, if we believe, as I have assumed in this discussion that we do believe, that educa-

tion is the foundation of our liberty and essential to its maintenance; and if it is also true — as I think could easily be shown if time permitted—that the maintenance of prosperity in a technical world depends upon progress in research and development, which in turn also depends upon education, we have, I think, every reason to be gratified with the progress which has been made and with the developments in educational theory and practice which have marked the days of our years. It is equally clear, however, that we must be gravely concerned to maintain the standards, to provide the teachers, to establish the facilities, not only for the continued growth and development of education, but for its very continuance in any acceptable form.

I have not the time to show, as I could easily show, that the only hope of caring for the vastly increased numbers of college students with whom we shall have to deal in a few years lies in our publicly supported institutions. If this is true, and I am absolutely confident it is, we shall have to indicate the strength of our belief in education as the foundation of liberty and prosperity practically, by the acceptance of increased taxation for the support of public schools and colleges and universities, as well as merely theoretically. I am confident that once our people understand the situation, they will do nothing less.

After all, education and scholarship are fundamental to our existence as a free people. In its simplest and most restricted meaning, scholarship involves knowledge. The absence of knowledge is ignorance, and in ignorance no free people can endure. In a broader sense, scholarship means competence, the ability to apply knowledge for the advancement of human welfare.

There is a startling illustration of what this means in a comment made by Raymond B. Fosdick in one of his reports of the Rockefeller Foundation just after the war, when he pointed out that "three times before in the history of the Roman Campagna the abandonment of hydraulic work due to war and the consequent cessation of agriculture brought on a widespread plague of malaria. Each time,

two centuries were needed to bring the area back to a normal state of health. The fourth time that war devastated this area, in World War II, it took one thorough application of DDT to reduce the danger of malaria infection almost to zero."

But scholarship goes even further. As I have said earlier, the true end of scholarship is not merely knowledge, not merely competence, but resourcefulness—the application of knowledge and competence to new unsolved and unexpected problems, the kind of resourcefulness that enabled Michael Pupin to remove the forest of telegraph poles and the confusion of electric wires from the streets of New York. If you will look in that Columbia Bicentennial picture book of New York City, by Kouwenhoven, you will be amazed at the forest of wires and poles; and they were removed by Michael Pupin, not by ingenious devices of wood, metals or ceramics, but by the solution of a differential equation, a piece of pure mathematics.

Finally, scholarship in its highest reaches goes beyond resourcefulness. It embodies standards of values, a determination of that which is good, indeed of that which is best, and thus relates itself to the highest that we know.

The purpose of education is well summarized in that sentence by which one of the greatest phrase-makers of our time described the university. "It is," said Winston Churchill, "a place where knowledge is garnered, learning stimulated, thought encouraged, and virtues inculcated."

If we make our schools and colleges places like that, and given adequate support we can do it, our liberty and our prosperity are safe.

(Applause)

DR. SHARP: Thank you, Dean Meder. May I say, sir, that I think the highest compliment I could pay you: that was as well done as a well prepared medical paper.

Ladies and gentlemen, this concludes the formal part of the program. Music and dancing will continue until midnight.

(The speakers' portion of the program was then concluded at 10 p.m.)

TRANSACTIONS OF THE WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF NEW JERSEY TWENTY-SEVENTH ANNUAL MEETING

The twenty-seventh annual meeting of the Woman's Auxiliary to The Medical Society of New Jersey was declared in session by the President, Mrs. Frank S. Forte, on Tuesday, May 18, 1954 at 9:00 a.m. in the Garden Room, Hotel Haddon Hall, Atlantic City.

The Rev. Father McMemmon of St. Nicholas Church, Atlantic City, gave the invocation.

The pledge of loyalty was repeated by all present.

Mrs. E. Harrison Nickman, President of the Atlantic County Auxiliary, gave the speech of welcome. Mrs. Paul E. Rauschenbach, President-Elect to the State Auxiliary, responded.

Mrs. Harry Subin, Convention Chairman, moved the acceptance of the convention program as planned. Motion was carried.

Mrs. Forte announced with regret the inability of Mrs. Leo J. Schaefer, President of the Woman's Auxiliary to the American Medical Association, to attend the convention due to serious illness in her family.

She introduced the following guests: Mrs. Thomas d'Angelo, immediate Past-President of the New York State Auxiliary; Mrs. Arthur Bennett, President of the New York State Auxiliary; Mrs. Hewitt Smith, wife of the president of the Medical Society of Delaware; Mrs. Allan Cruchley, President of the Delaware State Auxiliary; and Mrs. Willard Preston, immediate Past-President of the Delaware State Auxiliary.

Upon motion by Mrs. Don A. Epler the minutes of the 26th Annual Session were accepted as printed.

The roll was called by the Recording Secretary, Mrs. D. Leo Haggerty. Present were: seven officers, four directors, four advisors, fourteen state committee chairmen, and eight county presidents.

Memorial service for departed members was conducted by Mrs. Gerald E. McDonnell, Fel-lowette, assisted by Mrs. Edward H. Dyer and Mrs. Clarence B. Whims.

Mrs. Forte announced Mrs. David B. Allman as timekeeper with two minutes allowed for reports.

The treasurer's report was given by Mrs. Thomas DeCecio, Treasurer, and showed a balance of \$4,547.62. Mrs. DeCecio presented the auditor's report. (Auditor—Mr. Willard Roberts, Trenton) Mrs. Paul Aszody moved the acceptance of both reports. Motion was carried.

Letters were read from Mrs. Frederic H. Steele, President of the Woman's Auxiliary to The Medical Society of Pennsylvania, expressing regrets that neither she nor the President-Elect, Mrs. Redding, could accept Mrs. Forte's invitation to the New Jersey convention; from Mrs. Thomas M. d'Angelo, accepting the invitation for herself and for Mrs. Arthur Bennett both of the New York State Auxiliary.

Mrs. Andrew C. Ruoff, First Vice-President, took the chair for the reading of the president's report. Mrs. John J. Torpey moved the president's report be accepted with thanks. Motion was carried.

Mrs. Lewis C. Fritts moved the reports of the state committee chairmen and county presidents be accepted. Motion was carried.

The president recessed the session for luncheon to reconvene at 2:30 p.m.

Following the luncheon, the General Session was called to order by Mrs. Forte.

Mrs. Allan Cruchley of Delaware, and Mrs. George H. Gildersleeve, of Connecticut were introduced.

Mrs. Samuel L. Winn, Credentials Chairman, reported a total registration of 329.

Mrs. Edward H. Dyer presented the following report of the Nominating Committee:

President—Mrs. Paul E. Rauschenbach
President-Elect—Mrs. Andrew C. Ruoff
First Vice-President—Mrs. Bertram J. L. Sauerbrunn

Second Vice-President—Mrs. Stewart F. Alexander
Recording Secretary—Mrs. D. Leo Haggerty
Treasurer—Mrs. Thomas DeCecio
Directors—Mrs. Clarence B. Whims and Mrs. Harry F. Suter

There being no further nominations, Mrs. Richard J. McDonald moved that the nominating ballot become the election ballot. Motion was seconded and carried.

Mrs. David B. Allman, Resolutions Chairman, presented the proposed revisions to the Constitution and By-Laws of the National Auxiliary. Upon motion by Mrs. Allman the revisions were adopted.

The following were elected to the Nominating Committee:

Mrs. Frank S. Forte, Chairman, Essex County
Mrs. Maurice Re—Bergen County
Mrs. William E. Dodd, Ocean County
Mrs. Don A. Epler, Essex County
Mrs. Louis S. Wegryn, Union County

Mrs. Forte appointed the following reading committee for the minutes of the annual session: Mrs. D. Leo Haggerty, Mrs. Asher Yaguda and Mrs. Richard J. McDonald.

Mrs. David B. Allman charged each new officer with the duties of her office. Mrs. Forte, retiring president, turned the gavel over to Mrs. Rauschenbach.

Following Mrs. Rauschenbach's speech of acceptance the 27th Annual Session of the Woman's Auxiliary to The Medical Society of New Jersey was declared adjourned.

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APPENDIX

APPENDIX 1

Resolution introduced by the Union County Medical Society and referred to Reference Committee "E".

WHEREAS, Congressman Charles A. Wolverton on January 6, 1954, introduced HR-6949 which would establish a federal corporation to reinsure the voluntary non-profit health plans, and

WHEREAS, Congressman Charles A. Wolverton and Senator Alexander Smith introduced on March 11, 1954, HR-8356 and S-3114 (identical bills) which would establish a federal corporation to reinsure virtually every type of health plan, providing it is based on prepayment, and

WHEREAS, federal reinsurance would be a form of federal subsidization of the health plans, and

WHEREAS, subsidization by any agent of government inevitably leads to control by government and to rapidly deteriorating performance of functions so subsidized, and

WHEREAS, subsidy proposals represent merely an intermediate step by the socializers towards their ultimate goal of complete government domination, and

WHEREAS, federal subsidy and control would materially weaken the voluntary plans by encouraging actuarially unsound insurance practices and thus make them a vehicle for complete socialization of medical care, and

WHEREAS, the voluntary plans of prepayment insurance have been enjoying a natural and healthy growth thus making it possible for more and more of the citizens to distribute the costs of their medical care through sound, actuarial insurance experience, and

WHEREAS, financial assistance to the voluntary plans—either through federal reinsurance or federal subsidy—is not and should never be the responsibility of a centralized federal government, and

WHEREAS, financing of the provisions of the various proposals for subsidization of the voluntary prepayment insurance plans would require millions of dollars which would have to be supplied through taxes from citizens already impoverished by existing needless and excessive taxation, and

WHEREAS, federal financial assistance to the insurance plans would be an unfair and immoral act because it would constitute unfair competition to the insurance plans which refuse the federal aid.

THEREFORE, BE IT RESOLVED that the members of the Union County Medical Society in regular session assembled this 14th day of April, 1954, oppose the passage of HR-6949 and HR-8356—S-3114 and all similar legislation which proposes federal reinsurance or direct federal subsidization of the voluntary and private health plans.

BE IT FURTHER RESOLVED that the Legislative Committee of the Union County Medical Society be directed to utilize all legitimate means to defeat legislation which proposes to subsidize

and control the voluntary non-profit prepayment and private health plans and that the President of the United States, and our Congressmen be informed of the Society's position of support for unsubsidized health plans and unalterable opposition to subsidized and controlled health plans.

APPENDIX 2

Resolution introduced by the Union County Medical Society and referred to Reference Committee "E".

WHEREAS, Congressman Charles A. Wolverton has introduced HR-6950 which would provide \$40 million over five years for long period loans to assist voluntary non-profit health associations to attain facilities and equipment, and

WHEREAS, such loans can be had privately thereby eliminating this type of expensive federal subsidization, and

WHEREAS, subsidization by any agent of government inevitably leads to control by government and to rapidly deteriorating performance of functions so subsidized, and

WHEREAS, financial assistance to voluntary, nonprofit health associations is not and should never be the responsibility of a centralized federal government.

THEREFORE, BE IT RESOLVED that the members of the Union County Medical Society in regular session assembled this 14th day of April, 1954, oppose the passage of HR-6950.

BE IT FURTHER RESOLVED that the Legislative Committee of the Union County Medical Society be directed to utilize all legitimate means to defeat HR-6950.

APPENDIX 3

Resolution introduced by the Union County Medical Society and referred to Reference Committee "E".

WHEREAS, Congressman Carl T. Curtis has introduced Social Security bill HR-6863 and Congressman Daniel A. Reed has introduced Social Security bill HR-7199 which would extend Social Security coverage to an additional 10,500,000 persons, of which 6,500,000 persons, including physicians, would be compelled to join the system, and

WHEREAS, there is growing sentiment throughout the nation that the Social Security program is basically wrong and actuarially unsound and should be repealed, and

WHEREAS, the Social Security System is based on a complete compulsory principle that is contrary to the essential principles of individual liberty and freedom.

THEREFORE, BE IT RESOLVED that the members of the Union County Medical Society in regular session assembled this 14th day of April, 1954, do hereby go on record as being unequivocally opposed to HR-6863 and HR-7199.

AND BE IT FURTHER RESOLVED that the Legislative Committee be instructed to use all legitimate means to bring about its defeat.

APPENDIX 4

Resolution introduced by the Union County Medical Society and referred to Reference Committee "E".

WHEREAS, this Society has on previous occasion gone on record as approving and supporting the Proposed 23rd Amendment, and

WHEREAS, the said Amendment has not as yet been adopted.

THEREFORE, BE IT RESOLVED that the members of the Union County Medical Society in regular session assembled this 14th day of April, 1954, reaffirm their support of the Constitutional Amendment to provide that: The government of the United States shall not engage in any business, professional, commercial, financial or industrial enterprise except as specified in the Constitution.

APPENDIX 5

Resolution introduced by the Union County Medical Society and referred to Reference Committee "E".

WHEREAS, certain threats to our free economy and to our Constitutional Government are daily becoming more apparent, and

WHEREAS, these threats make it more essential than ever that we know the position of candidates for public office on certain basic issues.

THEREFORE, BE IT RESOLVED that the members of the Union County Medical Society in regular session assembled this 14th day of April, 1954, urge every member of the Society to enlist the support and assistance of local organizations in determining the stand of all candidates for state or national office on the two great basic issues of our time: (1) The Bricker Amendment and (2) The Proposed 23rd Amendment which provides "The government of the United States shall not engage in any business, professional, commercial, financial or industrial enterprise except as specified in the Constitution."

APPENDIX 6

Resolution introduced by the Mercer County Medical Society and referred to Reference Committee "C".

WHEREAS, The medical profession of Mercer County has at all times attempted to practice medicine and surgery according to the highest standards of ethics and with the humanitarian purpose of guarding the welfare of the patient foremost in its mind; and

WHEREAS, All our local ACS accredited hospitals follow the dictates of the ACS and only those physicians qualified and appointed according to these requirements are permitted to operate or assist in the operating pavilions. The following is a direct quotation from the Manual of Hospital Accreditation, found in Bulletin, ACS, dated December 1951, Vol. 36, No. 4, Page 341, Paragraph A2-b-1 "Personnel of each service shall be qualified by training and demonstrated competence and shall be granted privileges commensurate with their individual abilities." These properly and appropriately appointed chiefs, associates and assistants willingly and gladly assist each other without financial consideration of any kind; and

WHEREAS, It has long been the custom in Mercer County for the referring physician to relinquish to the surgeon the complete control and management of the patient and to permit the surgeon to exercise his surgical judgment in each case without pre- or postoperative interference or coercion; and

WHEREAS, The referring physician is usually, but not always, a general practitioner who never pretends that his services are so essential to the surgeon as to require his active assistance in any operative procedure; and

WHEREAS, Most physicians in Mercer County practicing surgery or the surgical specialties restrict themselves as much as possible to their specialties, leaving the field of general practice to the general practitioner, where it belongs; and

WHEREAS, Any financial transactions or arrangements between a patient and his physician are such as to be of no concern, directly or indirectly, to anyone but themselves, the relative value of service rendered by the physician and his reasonable financial remuneration for same being strictly a matter for himself and his patient to determine; and

WHEREAS, The physicians of Mercer County recognize the unfortunate conditions existing in certain areas wherein some few hospitals, not accredited by the ACS (or JCAH), function without adequate staffs, residents or interns, and frequently utilize fellow colleagues not specially trained (and at times the referring physician) to assist in surgical procedures. We believe, although we do not condone nor will we adopt this procedure, that payment of the assistant in such cases may be deemed ethical, provided payment is never made to the referring physician, provided further that separate self-explanatory statements are rendered directly to the patient, provided further that there must never be any pretense as to who performs the surgery, nor that there be any question that the operating surgeon should be in charge of the case, and provided further that the entire transaction is open and above board; and

WHEREAS, The physicians of Mercer County believe the entire question of payment of an assistant, unless by salary and/or by contract salary, is fraught with so many pitfalls which will, in our belief, inevitably lead to fee-splitting in all its distressing forms, that we cannot countenance its practice in the county; and

WHEREAS, On the basis of the above reasoning, and in order to impress upon the members of The Medical Society of New Jersey the seriousness with which we view this step, the Mercer County Component Medical Society respectfully urges the medical profession of New Jersey to resist any move on anyone's part to promote a change in the present method of payments of fees by the Medical-Surgical Plan of New Jersey, in which separate fees would be paid for pre- and postoperative medical services rendered by others than the surgeon and for fees to be given for any assistance rendered the surgeon by the other physicians; and

WHEREAS, We believe that the more ethical course to follow would be to find other and more appropriate means of paying for services rendered by the general practitioner, or others, so that, if

possible, these latter gentlemen can share more equitably in the insurance benefits of the Medical-Surgical Plan of New Jersey; and

WHEREAS, We believe we are acting entirely within our rights as free men to discontinue our association as participating physicians, should The Medical Society of New Jersey bring about a change in the present procedure of payment of fees by the Medical-Surgical Plan of New Jersey and substitute therefor that procedure which would include the payment for pre- and postoperative care beyond that already agreed to, and include payment of assistants in surgery, this, in our mind, constituting a breach of contract, in that the Medical-Surgical Plan of New Jersey would then force us to practice a brand of medicine and surgery which we believe is not of the character or caliber we desire, and would indicate or imply compliance on our part in a practice not commensurate with our standards or our ideals. Therefore, be it

RESOLVED, That the Board of Trustees of The Medical Society of New Jersey be apprized of this action on the part of the Mercer County Component Medical Society; and be it further

RESOLVED, That the Board of Trustees of The Medical Society of New Jersey be requested to bring notice of this action before the House of Delegates at its next annual meeting.

APPENDIX 7

Resolution introduced by the Gloucester County Medical Society and referred to Reference Committee "C".

WHEREAS, many of the members of the smaller county medical societies would like to enjoy the benefits of the New Jersey Hospitalization Plan as a group; and

WHEREAS, some smaller societies such as Gloucester have difficulty in enrolling the necessary 65 to 70% of their members in said Blue Cross Plan; and

WHEREAS, The Medical Society of New Jersey as a group could join the Blue Cross with only 50% participation:

THEREFORE BE IT RESOLVED, that the House of Delegates here assembled request the Board of Trustees of the State Medical Society to investigate the possibilities of such a plan, with the mechanics of collections of premiums, etc., being left to the discretion of the Hospitalization Plan.

APPENDIX 8

Resolution introduced by the Sussex County Medical Society and referred to the Reference Committee on Miscellaneous Business.

WHEREAS, There has been a definite increase in the number of drunken driving cases in the state of New Jersey.

WHEREAS, There has been considerable increase in the number of appeals following conviction in lower courts in these cases.

WHEREAS, There has been an increasing number of reversals of these convictions on appeal because of lack of incontestable and acceptable tests for alcoholism.

WHEREAS, This has resulted in considerable embarrassment and harassment of the medical profession in the state of New Jersey, notwithstanding the law enforcement bodies.

NOW, THEREFORE BE IT RESOLVED, That the House of Delegates of The Medical Society of New Jersey, devise ways and means to correct the abuses that exist in this respect, and recommend such procedures as may be necessary for incontestable proof of alcoholic intoxication, to the Legislature of the sovereign state of New Jersey, for enactment of such devices and recommendations into law of the state that may be necessary for their enforcement.

APPENDIX 9

Resolution introduced by a delegate from Essex County and referred to Reference Committee "C".

WHEREAS, the Medical-Surgical Plan allows a greater fee for emergency services within forty-eight hours when these emergency services are performed in the outpatient department or the Emergency Ward of a hospital, as compared to a lesser fee allowed for the same emergency services when performed in a private physician's office, and

WHEREAS, the actual location where emergency services are performed is incidental when the same services are performed in the private physician's office as in the outpatient department or emergency ward of a hospital.

THEREFORE, BE IT RESOLVED, that the same fee be allowed by the Medical-Surgical Plan for emergency services when performed in the private physician's office as is allowed in the outpatient department or emergency ward of a hospital.

APPENDIX 10

Resolution introduced by the Council of the Essex County Medical Society and referred to Reference Committee "B".

WHEREAS, a Pension Plan for the employees of The Medical Society of New Jersey was presented to the Board of Trustees on April 4, 1954, and acted upon within an hour, which did not allow for careful consideration of the items therein, and

WHEREAS, the Essex County Medical Society has caused to be prepared an alternative plan which provides for adequate pension for the employees comparable to the pension plans of other State Societies,

THEREFORE, BE IT RESOLVED, that this House of Delegates direct the Board of Trustees to study several pension plans and report back at the next meeting of the House of Delegates.

APPENDIX 11

Resolution from the Hudson County Medical Society, referred to Reference Committee "C".

WHEREAS, under the present schedule, the Medical-Surgical Plan compensates only the operating surgeon, and makes no provision for paying the referring physician who assists at the operation or who renders pre- and postoperative care.

BE IT RESOLVED, that The Medical Society of New Jersey shall recommend to the Trustees of the Medical-Surgical Plan of New Jersey:

- a. That in making payment for surgical procedures, the Plan designate the amount payable as payable for surgical services, and not as the surgeon's fee.
- b. That the Plan pay both the surgeon and the assistant who assists at the operation or who renders preoperative or postoperative care.
- c. That if sufficient funds are not available to pay both the surgeon and the assistant, the Plan divide the payment proportionately between the two; in other words, the Plan compensate both the surgeon and the assistant from the amount payable under the plan.
- d. That the patient be notified by the Plan of the payment being made to the surgeon and to the assistant.

APPENDIX 12

Resolution drafted by Dr. Henry Brodtkin of the Essex County Medical Society and introduced by the delegation from Essex County. This was referred to the Reference Committee on Miscellaneous Business.

WHEREAS, the New Jersey Rehabilitation Commission is vitally interested in providing all rehabilitation services necessary for the physical and vocational adjustment of physically disabled citizens of New Jersey; and

WHEREAS, the Commission is dependent upon the medical profession for diagnosis, surgery, treatment and all other medical services necessary to the adjustment of the individual; and

WHEREAS, the Commission is cognizant of a lack of information on the part of many physicians of the advantages, functions and services available to the disabled citizen through the Commission; and

WHEREAS, there is great need for a closer relationship between the profession and all other agencies and individuals interested in the physical and vocational adjustment of the disabled;

NOW, THEREFORE, BE IT RESOLVED, that the Commission respectfully petitions The Medical Society of New Jersey to undertake a comprehensive, educational program which presents prescribed procedures to the attention of the profession and the public; and be it

FURTHER RESOLVED, that the Commission requests the Society to take such action as it may deem advisable and appropriate to bring about a study and recommendations for a practical procedure to carry out the intent of this resolution.

APPENDIX 13

SUPPLEMENTAL REPORT OF MEDICAL-SURGICAL PLAN OF NEW JERSEY

(To Reference Committee "C")

The Board of Trustees of Medical-Surgical Plan of New Jersey respectfully submits the following Supplemental Report to its Annual Report to the House of Delegates of The Medical Society of New Jersey:

1. FIELD SERVICE PROGRAM

On March 23, 1954, Medical-Surgical Plan inaugurated a "Field Service Program" for physicians and their office aides. This program is being conducted on an experimental basis, following an extended study of the experience of other Blue Shield Plans with this type of physician relations activity, and the needs and opportunities of Medical-Surgical Plan.

During the past several weeks, a member of the Plan staff has been conducting a field service program in Bergen and Passaic counties. This program is devoted principally to providing information as to claim procedures and reporting requirements of the Plan.

In each county in which this work has been or will be undertaken, prior consultation and clearance will be arranged with the Advisory Committee to Medical-Surgical Plan in the county involved.

Arrangements are made for our Field Representative to visit the local hospitals and set up an information desk in or adjacent to the doctors' staff room or lounge. Another most important feature of this service is contact with physicians' secretaries in order to acquaint them with the administrative procedures and requirements of the Plan. Lectures and classroom work have also been presented at vocational institutions for the students in the medical secretarial courses.

The reactions from physicians and their office personnel thus far have been very favorable. The benefits, of course, run both ways, as the Plan is able to become more accurately informed of the problems, suggestions and attitudes of physicians in regard to Plan policies.

2. ANESTHESIA SERVICES AND PARTICIPATION OF ANESTHETISTS

At present only 46% of the specialist anesthesiologists in the state are Participating Physicians. This percentage is decreasing as more anesthetists resign as Participating Physicians. 82% of all practicing physicians in the state are Participating Physicians.

The Trustees of the Plan are concerned with the future policy of the Plan relative to inclusion of anesthesia as an eligible service unless the percentage of participation of anesthetists is increased to the level of participation of the rest of the profession. There are many complaints arising from subscriber groups because of this discrepancy.

The Trustees have requested the Medical Director to seek an opportunity to address the membership of the New Jersey Society of Anesthesiologists and bring to their attention the fact that unless the participation of anesthesiologists is increased to that of the rest of the profession, the Plan will have to reconsider its policy concerning eligibility of anesthesia services for Plan payment.

3. LEGISLATION RELATING TO OPTOMETRISTS AND CHIROPODISTS

The Plan is informed of legislation which has been enacted (concerning chiropodists) and legislation which is currently before the legislature (concerning optometrists) purporting to supplement the

Enabling Act under which the Plan operates for the purpose of making eligible for Plan payment services rendered by chiropodists and optometrists within the scope of their practice.

The possible complications inherent in such approaches is evident by the fact that at present there still are some services of physicians that are excluded from Plan payment (i.e. radiology, pathology, medical care, etc.).

The Plan is of the opinion that its contemplated program for expansion of coverage for services rendered by physicians, particularly those services rendered outside of hospital, may be compromised by this legislation and possible future legislation concerning other professional groups.

4. TENTATIVE DATE FOR ISSUANCE OF NEW CONTRACT

The Plan has been proceeding as quickly as possible to develop and issue a new series Subscription Contract in accordance with the proposal approved by the House of Delegates at its meeting last year. The steps required have been reviewed in the Annual Report already submitted to this House of Delegates.

If the only consideration in regard to the issuance of a new series Subscription Contract involved the proposed changes approved by the House of Delegates last year, the Plan would be in a position to proceed without delay.

However, there may be delay in issuing a new series Contract pending clarification with respect to non-inclusion of services of other than fully licensed physicians covered under Plan contracts. The Medical Society of New Jersey is opposed to including services of other than fully licensed physicians.

In the meantime, certain important changes can be and are being made by the Plan under its current Subscription Contract.

1. Designation of husband as the Subscriber in all new applications for Husband Wife and Family Contracts.
2. Possible issuance of non-group Subscription Contracts.

5. COMMUNICATIONS FROM SUBSCRIBER GROUPS REGARDING PROPOSED CONTRACT CHANGES

In the words of the Subscription Contract, "The Plan is operated for the benefit of its Subscribers."

The announcement of the Plan's proposed Contract changes at the time of their approval by the House of Delegates of The Medical Society of New Jersey in May 1953, evoked certain reactions from labor and employer groups representing large segments of the Plan's enrollment.

To develop a better understanding of the problems and purposes of the Plan among these groups, conferences have been held during the year with representatives of industry and labor. A brief reference to these conferences has been included in the Annual Report of the Plan to this House of Delegates.

At these conferences certain proposals have been offered for consideration.

There has been an unmistakable unanimity among all parties that any appreciable increase in the Subscription Rate for a new Subscription Contract, over and beyond the present Subscription Rate, should be avoided—especially with reference to the Family Contract Rate. The Board of Trustees recorded itself before this House of Delegates in May 1953 as supporting this view, and the Board still believes it advisable to avoid any substantial increase in Subscription Rate.

Secondly, the request or suggestion has been made by certain groups that the Plan reconsider the "income limits" for "service benefits". It has been recognized that the proposal to apply the present "income limit" of \$5000 to the combined income of Subscriber and spouse (in all cases in which both a husband and wife jointly covered by a Subscription Contract are earning an income) will result in many family units being removed from the "service benefit" classification. As a partial offset to this, and in recognition of the differences in relative purchasing power and living standards as between a single person earning \$5000 and a family of several persons having the same income, the suggestion has been made that the income limit for multiple-person Contracts be adjusted upward.

Objection has also been raised in certain quarters to the proposal to exclude prenatal care as an eligible service, as approved by this House of Delegates last year.

Again it has been requested, both by certain subscriber groups and by certain physicians, that the Plan reconsider its decision to eliminate consultations as an eligible service. On this matter, the Plan awaits the recommendations of The Medical Society of New Jersey, resulting from the study of this problem which we understand has been proceeding during the past year.

Suggestions have been made by certain labor union groups that the scope of Plan benefits be radically expanded, to include office surgery without limitation, medical care in home and office, and diagnostic procedures. This proposal would, of course, inevitably involve a very substantial increase in Subscription Rates.

The Trustees have described a few of the more important requests or proposals that have been made by labor and industrial representatives because the Trustees feel that the medical profession fully shares the desire of the Plan to give every reasonable consideration to any constructive suggestion emanating from the Subscribers. Whatever decisions are ultimately made, with respect to these or other questions involving the Plan's Subscription Contract must necessarily represent an adjustment between the differing views of the several interested parties, and must be reasonably acceptable to all of them.

6. FEDERAL HEALTH REINSURANCE BILL

The "Federal Health Reinsurance Bill" was introduced in the Senate by Senator H. Alexander Smith of New Jersey, and in the House of Representatives by Congressman Wolverton, also of New Jersey. It is recognized as an Administration proposal.

The purpose of this Act is stated as being "to encourage and stimulate private initiative in making good and comprehensive health services generally accessible on reasonable terms through adequate health service prepayment plans to the maximum number of people. . . ."

There has been general commendation of the President's overall objective namely "that the means for achieving good health should be accessible to all, regardless of a person's location, occupation, age, race, creed or financial status."

The general criticism of the particular proposed legislation has been that it is not likely to accomplish the desired objective.

It is the consensus that there is little likelihood of the proposed legislation being enacted in its present form.

7. BLUE SHIELD PLANS AFFIRM SUPPORT OF SERVICE BENEFIT PRINCIPLE

One of the most significant actions taken by the national association of Blue Shield Medical Care Plans at its Annual Conference held in New York City, April 4 to 8, 1954, was the adoption of a resolution affirming their support of the service benefit principle.

The preamble to this resolution asserts that the

public "has demonstrated its desire for service benefits rather than cash indemnity as evidenced by the fact that on December 31, 1953, of the 28,079,913 Blue Shield subscribers enrolled, 20,158,327, or 71.8% of the total, were protected by Plans providing the combination service-indemnity type of benefit."

The preamble further cited, as evidence that the majority of physicians associated with Blue Shield Plans approve the service benefit principle, the fact that 73% of all Plans provide either a full service or combination service-indemnity benefit to their subscribers.

For these and other reasons, the Blue Shield Medical Care Plans recorded themselves as favoring the service benefit plan for people of average income and recommended "that member plans operating on an indemnity basis consider converting to the service-indemnity type of operation so that all Blue Shield subscribers of average income may receive guaranteed financial protection against the cost of serious illness."

Respectfully submitted,

BOARD OF TRUSTEES,
Medical-Surgical Plan of New Jersey
(New Jersey Blue Shield Plan)

APPENDIX 14

REPORT OF THE NOMINATING COMMITTEE

HARROLD A. MURRAY, M.D., Chairman

Candidates proposed by Committee (All candidates are "M.D.")	Term Ending	Office	Term (Years)
Vincent P. Butler, Jersey City	May 1955	President-Elect	1
Lewis C. Fritts, Somerville	May 1955	First Vice-President	1
Albert B. Kump, Bridgeton	May 1955	Second Vice-President	1
Marcus H. Greifinger, Newark	May 1955	Secretary	1
Jesse McCall, Newton	May 1955	Treasurer	1
Joseph P. Donnelly, Jersey City	May 1957	Trustee, 2nd District	3
Lloyd Hamilton, Lambertville	May 1956	Trustee, 3rd District	2
L. Samuel Sica, Trenton	May 1957	Trustee, 3rd District	3
Reuben L. Sharp, Camden	May 1957	Trustee, 4th District	3
Harrold A. Murray, Newark	May 1957	Eleventh Trustee	3
Kenneth E. Gardner, Bloomfield	May 1957	Councilor, 1st District	3
Daniel Featherston, Asbury Park	May 1957	Councilor, 4th District	3
J. Wallace Hurff, Newark	Dec. 1956	A.M.A. Delegate	2
Elmer P. Weigel, Plainfield	Dec. 1956	A.M.A. Delegate	2
L. Samuel Sica, Trenton	Dec. 1956	A.M.A. Delegate	2
Harrold A. Murray, Newark	Dec. 1954	A.M.A. Alternate	1
John H. Rowland, New Brunswick	Dec. 1956	A.M.A. Alternate	2
Herschel Pettit, Ocean City	Dec. 1956	A.M.A. Alternate	2
Ralph M. L. Buchanan, Phillipsburg	Dec. 1956	A.M.A. Alternate	2
Harrold A. Murray, Newark	May 1955	Delegate to New York	1
William F. Costello, Dover	May 1955	Alternate to New York	1
C. B. Blaisdell, Asbury Park	May 1955	Delegate to Connecticut	1
Blackwell Sawyer, Toms River	May 1955	Alternate to Connecticut	1
J. Lawrence Evans, Jr., Leonia	May 1957	Publication Committee	3
Herschel Pettit, Ocean City	May 1960	Committee on Finance and Budget	6

APPENDIX 15

FINANCE AND BUDGET COMMITTEE

DAVID B. ALLMAN, M.D., Chairman, Atlantic City
(To Reference Committee "B")

Below is a copy of the Requested Budget for 1954-55 which has been approved by your committee and the Board of Trustees.

In figuring the per capita assessment for 1955, the actual figure required to meet the budget is \$41.14. For several years the assessment has been kept at \$25.00 and surplus funds have been used to meet those expenses over income. Your committee feels that with the depleted surplus an increase in dues should be made this year to meet the budget.

RECOMMENDATIONS

1. That the attached budget in the amount of \$160,198.00 be adopted.

2. That the per capita assessment for 1955 be \$30.00.

A-1	Executive Salaries	\$ 42,800.00
A-2	Executive Office Salaries	24,456.00
A-3	Executive Office Expenses	2,000.00
A-4	Executive Travel	1,680.00
A-5	House Maintenance	8,802.00
A-6	Treasurer	2,500.00
A-7	Finance and Budget Committee...	250.00
A-9	Audit	450.00
A-10	Secretary	3,000.00
A-11	Salary Taxes	1,319.00
A-12	Insurance	1,473.00

B-1	Journal Publication	5,000.00
B-5	Journal Office Expenses	500.00
B-6	Journal Travel	100.00

C-2	Welfare Committee	800.00
C-3	Legislative Committee	7,500.00
C-4	Public Health Committee	1,400.00
C-5	Public Relations Committee	13,500.00
C-6	Medical Practice Committee	1,000.00

D-1	President and Other Officers	4,500.00
D-2	A.M.A. Delegates	5,550.00
D-8	Woman's Auxiliary	6,518.00
D-13	Medical Education Committee	100.00
D-20	Medical-Dental Liaison Committee	250.00
D-21	Medical-Hospital Liaison Committee	250.00
D-22	Medical-Legal Liaison Committee	250.00
D-23	Membership, Directory, Physicians Placement	4,000.00
D-24	Medical Research Committee	500.00
D-25	Medical School Committee	6,000.00
D-26	Medical-Pharmaceutical Liaison Committee*	250.00
D-27	Emergency Medical Service, Civil Defense Committee*	500.00

E-1	Board of Trustees	1,500.00
E-2	Contingent	10,000.00
E-4	Judicial Council	500.00

F	Legal	1,000.00
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TOTAL\$160,198.00

* This is a new item.

APPENDIX 16

SPECIAL COMMITTEE ON THE APPORTIONMENT OF FEES UNDER MEDICAL-SURGICAL PLAN

JOHN E. LEACH, M.D., Chairman

(Referred to Reference Committee "C")

At the direction of the 1953 House of Delegates, the Board of Trustees established a Special Committee on the Problem of Division of Fees Under Medical-Surgical Plan. This committee consists of a member from each of the twenty-one county medical societies.

After several meetings devoted to the investigation of the whole problem, the committee adopted the following resolution on March 14, 1954. The committee then submitted the resolution to the county medical societies for approval or rejection. The resolution is detailed below.

The counties have reported their reaction to the resolution as follows:

Seven counties approved the resolution in its entirety.

Six counties rejected the resolution in its entirety.

Four counties partly approved and partly disapproved.

One county reported no action.†

Three counties failed to report **

In consequence, your chairman at this time finds it impossible to make a definite report concerning the desire of the county medical societies as regards the disposition of this matter.

I request that the special committee be continued until such time as it can make a definite report, and that the committee be empowered to submit that report as soon as it is available to the Board of Trustees.

A break-down of county action on the resolution appears at the end of this report.

RESOLUTION ON APPORTIONMENT OF FEES APPROVED BY THE SPECIAL COMMITTEE ON MARCH 14, 1954

WHEREAS, for some time it has been the recommendation of many members of The Medical Society of New Jersey that means be investigated to bring about an ethical division of payment of surgical fees under the Medical-Surgical Plan so that compensation might be made to an assisting physician; and

WHEREAS, the House of Delegates of The Medical Society of New Jersey in 1953 recommended "that the problem of division of surgical payment by Medical-Surgical Plan is such an important and controversial one that it should be referred to the Board of Trustees of the Medical Society with a recommendation that a committee be appointed, comprising a representative of each component county medical society, to study this problem during the coming year and to make definite recommendations to the Board of Trustees for presentation to the House of Delegates at its next annual meeting"; and

**The County Medical Societies which failed to report were Cape May, Ocean and Sussex.

† Essex County did not take definite action.

WHEREAS, in consequence of the foregoing, this Special Committee was established and activated by the Board of Trustees; Therefore Be It

RESOLVED, that this committee in furtherance of its designated function offers the following recommendations for the solution of the problem and solicits the official reaction of all component county medical societies:

1. That the physician who assists at the operation, excluding interns and residents, be paid for services rendered.

2. That the qualifications of surgical assistants be passed upon by the chiefs of surgical services in the hospitals in which they render such surgical assistance.

3. That payments be made by Medical-Surgical Plan without reduction in the prevailing surgeons' fees and within the framework of the Plan's financial ability to pay such fees.

4. That if the Plan is unable to compensate qualified surgical assistants on the basis suggested above, such surgical assistants be permitted to bill patients in person for services rendered.

COUNTY REACTION TO THIS RESOLUTION

Atlantic—Resolution approved.

Bergen—Point 1 approved; Point 3 opposed; Points 2 and 4 deleted. Proposed substitution: "That the total fee for surgeon and assistants shall not exceed that allowed by this Plan."

Burlington—Resolution opposed.

Camden—1. We feel definitely that an assistant to the operating surgeon should be recompensed unless he is in the process of being trained.

2. Camden County is in the area of Greater Philadelphia which is a teaching medical center and all of the accredited hospitals in our area are staffed with enough interns and residents so that nonaccredited assistants or assistants (not in training) are not necessary.

3. There are several attending surgeons at our hospitals who have assistants in their offices who are on either a salary or associated in a junior partnership. The attending surgeon renders a bill to the patient which is all inclusive and then he either pays the assistant by salary or pays the percentage of the partnership. This practice also is present among the medical men.

4. Camden County feels that in those communities where there is a lack of residents or interns the surgeon should be training one or two men rather than have as an assistant the referring physician.

5. We cannot see how any plan set up according to the proposed resolution would not be liable to lead to so-called fee-splitting.

Cape May—Failed to report.

Cumberland—Resolution approved.

Essex—No action on resolution in view of the stand taken by the A.M.A. on this question.

Gloucester—Resolution approved.

Hudson—Resolution opposed. Proposed substitution:

1. That in making payment for surgical procedures, the Plan designate the amount as payable for surgical services, and not as the surgeon's fee.
2. That the Plan pay both the surgeon and the assistant (or the referring doctor) as the case may be.
3. That if sufficient funds are not available to pay both the surgeon and the assistant (or referring doctor) in full, the Plan divide the payment proportionately between the two; in other words the Plan compensate in part, both the surgeon and the assistant (or referring doctor).
4. That the patient be notified by the Plan of the payment being made to the surgeon and to the assistant (or the referring doctor).

NOTE:—The physician who has rendered pre-operative or postoperative care is termed the "referring doctor" in this proposal.

Hunterdon—Resolution approved.

Mercer—Resolution opposed. Introducing own resolution opposing any change in present method of payments.

Middlesex—Approved the resolution.

Monmouth—Resolution opposed.

Morris—Points 1, 2, and 4 approved; divided opinion on Point 3.

Ocean—Failed to report.

Passaic—Points 1, 2 and 3 approved. Point 4, propose following substitute: "That, if the Plan is unable to compensate qualified surgical assistants on the basis suggested above, there be a revision of surgeon's fees to allow for payment of the assistant."

Salem—Resolution approved.

Somerset—Resolution approved.

Sussex—Failed to report.

Union—Resolution opposed.

Warren—Resolution opposed.

APPENDIX 17

COMMITTEE ON MEDICAL DEFENSE AND INSURANCE

J. WALLACE HURFF, M.D., Chairman, Newark
(To Reference Committee "D")

ACCIDENT AND HEALTH INSURANCE

During the past year we again reached the highest ratio of participation in our accident and health insurance program underwritten by the National Casualty Company through our authorized accident and health insurance brokers, E. & W. Blankstein of Jersey City. Approximately 3350 of our members, in excess of 75 per cent of our possible eligibles, hold policies.

Claims have been paid to over 400 of our members who were disabled during the year by either accident or sickness—a little better than one out of every ten members. The smallest claim paid was \$10. and the highest was \$3600.

Our accident and health insurance brokers have received during the year the usual large number of letters from satisfied claimants testifying to prompt and just claim settlements, a characteris-

tic of the service that the National Casualty Company has rendered our members during more than twenty years of association. No claimant for benefits had need of recourse to your Committee on Medical Defense and Insurance under our unique "arbitration clause" with the National Casualty Company, which provides that the Committee on Medical Defense and Insurance of the State Society is the sole arbitrator in the event of a claim dispute.

We are also pleased to report that our group plan with the National Casualty Company, through E. & W. Blanksteen, is stronger than ever, owing to the continued expansion in the "Blanksteen Pool" of professional societies from coast to coast, numbering approximately 35,000 professional policyholder participants.

Dun and Bradstreet Financial Reporting Agency gives the Company an A-plus, which is the highest rating any Company can obtain from the standpoint of stability and payment of claims.

RECOMMENDATION

The Committee recommends that the National Casualty Company, through the representation of E. & W. Blanksteen, be continued because it has served us well and its policy is the best offered for group protection.

PROFESSIONAL LIABILITY INSURANCE

A review of our medical liability problem for the year 1953-1954 does not present a very favorable outlook. A national survey of the liability situation has been completed by your Committee, with responses from forty states. The picture throughout the nation reflects the withdrawal of group form of insurance and the substitution of insurance on an individual basis, a trend which is analogous to the present situation in New Jersey. Where insurance has been sold on an individual basis, there is a trend to selectivity. In many states doctors complain because collateral or supporting insurance has been required. There was a general rise of premium rates throughout the country promulgated by the National Bureau of Casualty Underwriters. At least 13 states reported 1 per cent or fewer claims and suits per 1000 of insured doctors. In New Jersey our ratio is approximately 2½ per cent and has not shown any increase in the past three years. However, the loss ratio from the standpoint of cost and money paid out on claims and suits has markedly increased.

In September 1952, we were confronted with an upward revision of rates and reclassification of practice, which it was hoped would lower the insurance company's loss ratio. These changes have improved the situation; but it would appear that further adjustments may be necessary before the ratio of losses to premiums can be stabilized. Since our insurance is purchased on an individual basis the status will be judged by the insurance carrier, first from the standpoint of risk, and second from the degree to which the individual doctor is willing to protect the interest of the profession as a whole. It is to the best interest of every insured doctor to give fullest cooperation to the insurance company at all times.

Your Committee is unanimous in its opinion that the doctors of New Jersey should secure their liability protection through our Official Broker, Faulhaber & Heard, Inc. The future of available liability coverage is not certain as individual complaints would not be heard, but the fact that in unity there is a great strength and that through it mutual benefits are to be obtained has been overwhelmingly evidenced during the past trying times. We urge the doctors of our state to give this appeal their serious consideration. We need the wholehearted support of every doctor in the state to deal with this most perplexing problem. It is not individual but mutual and can be best served collectively rather than individually. We of the Committee stand ready at all times to be of assistance whenever needed.

The Committee feels that the state membership should be polled in order to secure accurate data as to the amount of coverage carried, suits or claims that have occurred, the name of the insurance carrier, and the source through which the policy has been obtained. This thought is introduced because of other states having been seriously handicapped in judging their true insurance status because of their inability to secure and study this type of information.

RECOMMENDATION

We again recommend continuing Faulhaber & Heard, Inc., as Official Broker as their services have proved of inestimable value to the doctors of the State Society for many years.

APPENDIX 18

MEDICAL EDUCATION

FRANCIS M. CLARKE, M.D., Chairman
New Brunswick

(To Reference Committee "D")

In making this report on the activities of the Committee on Medical Education for the past year, the Committee cannot do better than to quote the opening paragraph of the report made to the President and House of Delegates in April 1953.

"This report of the Medical Education Committee makes reference to the reports previously submitted to the Society in the years of 1951 and 1952. In these latter reports the need for a full time Executive Staff to carry out the work of the Committee, and a comprehensive outline of the work and purposes of the Committee, were presented. In the report of 1952, it was stated that the Chairman of the Committee was engaged in discussions with prospective benefactors, looking forward to financial support for the activities of the Committee from outside the Society. A number of interviews were held, and while the plan presented met with the most cordial and sympathetic reception, the same complicating factors were encountered in every instance; namely, the questions of the proposed Medical School for New Jersey, and interest in the National Education Fund. Following consultation with responsible officers of the State Society, solicitations for a subsidy for the furtherance of the work of the Medical Education Committee within the State were abandoned, in

order not to confuse the interest of people who either are, or might be, interested in these other very important undertakings. The Committee has therefore engaged in no organized educational activities during the past year."

The situations and conditions as outlined in this portion of this former report have persisted and have remained unchanged, and for these same reasons, the Committee has been inactive during the past year.

APPENDIX 19 CHEST DISEASES

JOSEPH A. SMITH, M.D., Chairman, Glen Gardner
(To Reference Committee "E")

No questions or items of business were referred to this advisory committee during the year. Therefore, it was not necessary to call the committee together.

APPENDIX 20 CHILD HEALTH

WILLIAM F. MATTHEWS, M.D., Chairman, Montclair
(To Reference Committee "E")

The Advisory Committee to the Subcommittee on Public Health of The Medical Society of New Jersey is still working on the Child Safety and Accident Prevention Program. There are many angles to this study and it will be some time before more definite report is available.

The final report on quarantine regulations has been completed by the State Board of Health and was submitted to us for further suggestions.

APPENDIX 21 HOSPITAL RELATIONSHIPS

LOUIS S. WEGRYN, M.D., Elizabeth
(To Reference Committee "E")

The committee has continued its work (begun two years ago) to make more hospital beds available. Although committees of physicians were organized in larger counties, and the similar work within hospitals was carried on by Hospital Intra-relationship Committees, greatest effort has been expended by hospital administrators.

General hospitals have a large turnover of patients, the average stay ranging from five to seven days. The costs of daily stay range from \$16 to \$22. Most hospitals, through their administrators, admit some economic loss after the first seven days of patient residence.

The Joint Commission on Accreditation of Hospitals has done much to improve the standards of medical care and has indirectly made more hospital beds available. Two of its "must" committees deserve mention: Tissue Committees which have done much to eliminate careless and unnecessary surgery and Joint Conference Committees which replace our present Hospital Intra-relationship Committees, or Advisory Committees on Hospital Relationships. The Joint Conference Committee represents the staff in meetings with the governing body of the hospital or a committee of that body. It has much to do with bringing about bet-

ter understanding among doctors, administrators, and governing bodies.

For some time the Blue Cross and Blue Shield Plans have been indirectly responsible for unnecessary admissions and longer stay of patients in hospitals. The unions in major industries, through their delegates continue to tell their worker-subscribers that they have full coverage, especially as regards x-rays, laboratory procedures, etc., if they stay in the hospital. The patients in turn feel that they are entitled to stay longer than advised by their physician because they have paid for coverage; and finally some few doctors send in cases that should properly be treated at home. These abuses are gradually being corrected by the Blue Cross and Blue Shield Plans, with the co-operation of hospital administrators and Joint Conference Committees.

Chronic cases in the near future will create a serious problem as regards hospital beds, since no adequate provisions have been worked out to take care of the aged, the chronically ill, and invalids.

The committee considered at length the resolution originally sponsored by the Hudson County Medical Society and adopted by the House of Delegates. The committee's opinion has been submitted to the Board of Trustees.

The committee acknowledges receipt of the recommendation referred by the Welfare Committee through the Subcommittee on Medical Practice concerning the establishment of an approved set of standing orders for nurses in institutions. Your committee requests time for further study of this recommendation.

APPENDIX 22 NOMINATIONS FOR EMERITUS MEMBERSHIP (Reference Committee on Resolutions and Memorials)

ESSEX COUNTY—

Dr. Adam H. Friedrich, Manasquan, formerly Newark; age 63; retired from practice; member in good standing for over twenty years.

Dr. Henry E. Ricketts, Newark; age 77; retired because of age; member in good standing for over twenty years.

Dr. Gustav A. Braun, East Orange; retired because of age; member in good standing for over twenty years.

APPENDIX 23 NOMINATIONS, BOARD OF GOVERNORS, MEDICAL SERVICE ADMINISTRATION (Referred to Reference Committee "C")

The Board of Trustees of The Medical Society of New Jersey recommends the following nominations for membership on the Board of Governors of Medical Service Administration of New Jersey:

Harry N. Comando, M.D.
William F. Costello, M.D.
Arthur W. Lunn
Royal A. Schaaf, M.D.
Rudolph C. Schretzmann, M.D.
Edward W. Sprague, M.D.
John S. Thompson
Thomas J. White, M.D.

APPENDIX 24

Introduced by: Board of Governors, Medical Service Administration through Board of Trustees of The Medical Society of New Jersey.

(Referred to Reference Committee "C")

WHEREAS, the most urgent problem in the distribution of medical care is that relating to the provision of medical and hospital care for elderly and aged, disabled, physically and mentally handicapped, indigent, medically indigent, unemployable and employed persons for whom adequate medical and hospital care cannot be provided by established prepaid sickness insurance plans operated upon sound insurance principles; and

WHEREAS, medical and hospital care for such persons can be provided on a "cost-plus" or "reimbursement" basis through tax subsidies from tax funds administered on a local level by nonpartisan, nonpolitical and nonprofit organizations, as has been demonstrated so clearly and convincingly by the Medical Service Administration of New Jersey in its operation of the City of Newark Plan for the provision of medical care to indigent and medically indigent; and

WHEREAS, the commendable objectives of President Eisenhower and the Secretary of Health, Education and Welfare, as set forth in proposed "reinsurance" legislation now before the Congress of the United States and sponsored by the Secretary of Health, Education and Welfare and her advisors, cannot possibly be attained without a huge subsidy by the Federal Government and without the risk of Federal control of the insurance industry and the socialization of medicine; and

WHEREAS, Senator H. Alexander Smith and Congressman Charles A. Wolverton of New Jersey, have demonstrated their interest in and concern for the attainment of a solution of the problem of the distribution of medical care by sponsorship of S. 3114 and H.R. 8356 respectively; therefore be it

RESOLVED, That the attention of Senator Smith and Congressman Wolverton be drawn to the really pressing facets of the medical care problem and that they be urged to concentrate their attention and effort upon legislation designed to make adequate medical and hospital care available to indigent and medically indigent persons and that these legislators be courteously reminded of the contribution already made by The Medical Society of New Jersey in the field of medical care of indigent and medically indigent persons by the establishment of the effectively functioning Medical Service Administration of New Jersey, and that The Medical Society of New Jersey offer to collaborate with Senator Smith, Congressman Wolverton and other legislators in the development

of an appropriate and satisfactory bill designed to provide adequate medical and hospital care for the indigent and medically indigent; and be it

RESOLVED further, that copies of this resolution be forwarded to the President of the United States, to the Secretary of Health, Education and Welfare, and to our Senators and Congressmen from New Jersey, Secretary and Chairman of the Legislative Committee of the A.M.A. and other appropriate agencies.

APPENDIX 25

JUDICIAL COUNCIL

SECOND DISTRICT

(Sussex, Bergen, Hudson and Passaic Counties)

JOSEPH M. KEATING, M.D., Chairman, Passaic

(Reference Committee "A")

No item of business was submitted to the Judicial Council of the Second District during the year 1953-1954. It was therefore unnecessary to call or hold any meetings of the Judicial Council of the Second District during that time.

This Judicial Council has participated in the discussions and deliberations of the Judicial Council of The Medical Society of New Jersey.

APPENDIX 26

NOMINATIONS, BOARD OF TRUSTEES, MEDICAL-SURGICAL PLAN

(Reference Committee "C")

The Board of Trustees of The Medical Society of New Jersey recommends the following nominations for membership on the Board of Trustees, Medical-Surgical Plan of New Jersey:

Charles W. Barkhorn, M.D.
Irving P. Borsher, M.D.
Harry N. Comando, M.D.
Patrick H. Corrigan, M.D.
William F. Costello, M.D.
Joseph P. Donnelly, M.D.
Joseph M. Keating, M.D.
Arthur W. Lunn
Paul Mecray, Jr., M.D.
Royal A. Schaaf, M.D.
Rudolph C. Schretzmann, M.D.
Edward W. Sprague, M.D.
John S. Thompson
Thomas J. White, M.D.
Carl K. Withers

APPENDIX 27

ANNUAL REPORT OF THE TREASURER

JESSE MCCALL, M.D., Newton

(Reference Committee "B")

STATEMENT OF RECEIPTS AND DISBURSEMENTS FOR FISCAL YEAR 1953-54

June 1, 1953 — May 12, 1954

RECEIPTS

Cash on Hand, June 1, 1953			\$203,224.75
Assessments:	1954 A.M.A.	State	Total
Atlantic County	\$ 3,475.00	\$ 3,350.00	\$ 6,825.00
Bergen County	10,500.00	10,725.00	21,225.00
Burlington County	1,800.00	1,825.00	3,625.00
Camden County	7,225.00	7,250.00	14,475.00
Cape May County	900.00	1,000.00	1,900.00
Cumberland County	1,600.00	1,806.25	3,406.25
Essex County	3,050.00	32,268.25	62,318.75
Gloucester County	1,650.00	1,700.00	3,350.00
Hudson County	14,125.00	13,500.00	27,625.00
Hunterdon County	900.00	925.00	1,825.00
Mercer County	8,260.00	8,237.50	16,497.50
Middlesex County	5,612.50	6,075.00	11,687.50
Monmouth County	4,875.00	5,718.75	10,593.75
Morris County	4,225.00	4,687.50	8,912.50
Ocean County		1,100.00	1,100.00
Passaic County	11,200.00	12,562.50	23,762.50
Salem County	1,025.00	1,025.00	2,050.00
Somerset County	2,100.00	2,150.00	4,250.00
Sussex County	775.00	800.00	1,575.00
Union County	12,100.00	12,587.50	24,687.50
Warren County	1,750.00	1,025.00	2,775.00
	<u>\$124,147.50</u>	<u>\$130,318.75</u>	<u>\$254,466.25</u>
A.M.A. Dues Refunds			125.00
1953 Membership Directory			1,502.50
Journal Advertising (net)			30,797.84
Commercial Exhibits			14,443.50
Interest Income			100.00
Sale of Maternal Welfare Books			784.00
Rents			600.00
Payroll Taxes			1,647.18
Refund of Budget Expenditures 1953-54			151.07
Miscellaneous—Middle Atlantic Regional Conference			151.52
A.M.A. Dues Collection			1,392.43
Fire Loss Repaid			164.88
Miscellaneous			139.71
Accounts Receivable			110.00
Total Receipts			<u>306,575.83</u>
TOTAL			<u>\$509,800.64</u>

DISBURSEMENTS

BUDGET ACCOUNTS	
A- 1—Executive Salaries	\$ 39,897.18
A- 2—Executive Office Salaries	17,244.09
A- 3—Executive Office Expenses	1,767.67
A- 4—Executive Travel	1,063.54
A- 5—House Maintenance	8,273.10
A- 6—Treasurer	1,853.50
A- 7—Finance and Budget Committee	98.26
A- 9—Audit	450.00
A-10—Secretary	1,892.64
A-11—Salary Taxes	953.28

A-12—Insurance	1,733.22
B- 1—Journal Publication	7,000.00
B- 5—Journal Office Expenses	330.41
C- 2—Welfare Committee	397.02
C- 3—Legislative Committee	3,224.23
C- 4—Public Health Committee	646.27
C- 5—Public Relations Committee	6,283.00
C- 6—Medical Practice Committee	228.42
D- 1—President	727.24
D- 2—A.M.A. Delegates	2,156.61
D- 8—Woman's Auxiliary	5,092.72
D-13—Medical Education Committee	32.01
D-20—Medical-Dental Liaison Committee	147.48
D-21—Medical-Hospital Liaison Committee	76.86
D-22—Medical-Legal Liaison Committee	32.01
D-23—Directory-Physicians Placement Service	858.11
D-24—Medical Research Committee	201.55
D-25—Medical School Committee	5,085.55
E- 1—Board of Trustees	774.50
E- 2—Contingent	6,754.52
E- 4—Judicial Council	161.46
<hr/>	
Total Budget Accounts	\$115,436.45
Accounts Payable, May 31, 1953	19,024.05
Annual Meeting	3,221.76
Journal Publication	22,970.52
Commissions	5,762.27
A.M.A. Dues	123,847.50
Janitorial Services	65.00
A.M.A. Dues Collection Expense	1,477.41
Assessments Refunded—1953	325.00
Permanent Home Account (House Committee Reserve)	6,726.11
Budget Expenditures—1952-53	1,626.35
Maternal Welfare Record Books Purchased	3,368.25
Miscellaneous	47.50
<hr/>	
Total Disbursements	\$303,898.17
Cash Balance, May 12, 1954	205,902.47
<hr/>	
TOTAL	\$509,800.64
<hr/>	

PERMANENT CAPITAL FUND

Cash	\$ 3,565.25
Investments	11,500.00
<hr/>	
Balance, May 12, 1954	\$ 15,065.25

ANNUAL MEETING RESERVE

Balance, June 1, 1953	\$ 5,305.02
Revenues, 1954 Booth Sales	14,443.50
<hr/>	
Total	\$ 19,748.52
Expenses, June 1, 1953 —	
May 12, 1954	3,221.76
<hr/>	
Balance, May 12, 1954	\$ 16,526.76

HOUSE COMMITTEE RESERVE

Balance, June 1, 1953	\$ 16,107.81
Revenue	764.88
<hr/>	
Total	16,872.69
Expenses, June 1, 1953 —	
May 12, 1954	6,726.11
<hr/>	
Balance, May 12, 1954	\$ 10,146.58

A.M.A. DUES COLLECTION

Balance, June 1, 1953	\$ 782.22
Revenue (1% of Collections)	1,392.43
<hr/>	
Total	\$ 2,174.65
Expenses, June 1, 1953 —	
May 12, 1954	1,477.41
<hr/>	
Balance, May 12, 1954	\$ 697.24

APPENDIX A

REPORT OF REFERENCE COMMITTEE "A"

ALBERT B. KUMP, M.D., Chairman

Reference Committee "A" met at 10:00 a.m., May 17, 1954, with all members present. Dr. Reuben L. Sharp attended the meeting as a representative of the Board of Trustees.

The *President's Report* was read. Dr. Decker is to be complimented for the successful year that now brings to a close his administration. The committee approves the recommendation for "the process that is presently under way to so organize, correlate and unify our activities within and without our Society, as to increase the effectiveness of all our efforts."

The *Report of the Board of Trustees* is a highly informative document. It offers us no recommendations. The committee strongly endorses the action of the Trustees regarding the specialty societies and urges a correlation of the programs so there is no conflict between the specialty groups and The Medical Society of New Jersey. Detailed reports of the Board of Trustees have been submitted in the pages of THE JOURNAL.

The *Report of the Secretary* is informative and contains an urgent request "that the county societies emphasize to their members the importance—even necessity—of maintaining membership in good standing at all times." This report includes information regarding the A.M.A. dues and the county societies are also requested to urge their members to settle all unpaid A.M.A. dues for previous years.

The second edition of the Membership Directory will be issued in 1955.

Your Reference Committee accepts the report of the *Judicial Council* with appreciation of the difficulties which confront it in working out a satisfactory mechanism for dealing with complaints. Your committee anticipates that the Council will carefully evaluate its own mechanism and will submit to the House of Delegates at the next meeting the Council's recommendations for such modifications as it feels will simplify the mechanism without detracting from its efficiency.

The *Report of the Executive Officer* evidenced the accomplishments of the Medical Society as a whole. It is a sincere expression of unified attainment.

Respectfully submitted,

ALBERT B. KUMP, M.D., Chairman
G. BARTON BARLOW, M.D.
WILLIAM H. HAHN, M.D.
EARL STAGE, M.D.
ROBERT A. WEINSTEIN, M.D.

Action: Page 18

APPENDIX B

REPORT OF REFERENCE COMMITTEE "B"

MARCUS H. GREIFINGER, M.D., Chairman

Reference Committee "B" met with all members present and considered the report of the Treasurer, the report of the Finance and Budget Committee, the report of the Publication Committee,

and a resolution introduced by the Essex County Medical Society re the proposed employees' pension-trust plan.

Each item in the Treasurer's report was carefully examined. The Committee recommends a vote of appreciation to Dr. Jesse McCall for his highly competent administration of the office of Treasurer.

The report of the Finance and Budget Committee was then considered. Dr. Allman was present and satisfactorily answered the many questions posed by the members of the Reference Committee and visitors. The following recommendations of the Finance and Budget Committee were approved:

1. That the budget in the amount of \$160,198. be adopted.
2. That the per capita assessment for 1955 be \$30.

The Reference Committee recommends the adoption of this portion of the report.

The Reference Committee commends the work of the Administrative Secretary in compiling and administering the budget for previous years and the current year.

The report of the Publication Committee as printed in the JOURNAL was then approved. The Committee wishes to commend the Publication Committee and the Editor for the progressive and high standards of the JOURNAL in substance and format. No appreciation would be complete without an expression of thanks to the Assistant Editor for her faithful and dependable service.

The resolution introduced by the Essex County Medical Society concerning the proposed employees' pension-trust plan was studied. After giving the resolution careful consideration and having been informed that other pension-trust plans had been proposed, it was the unanimous opinion of the Committee that a pension-trust plan be adopted for our employees. It was then decided that the resolution submitted by the Essex County Medical Society be tabled. Your Reference Committee recommends that the Board of Trustees appoint a committee to study several pension-trust plans and report back to the House of Delegates at its next meeting.

I wish to express my thanks to all members of my committee, who so diligently went over these financial reports and gave careful consideration to the resolution proposed.

The Reference Committee moves the adoption of this report.

MARCUS H. GREIFINGER, M.D.,
Chairman

MARY BACON, M.D.
JOHN H. ROWLAND, M.D.
HARRY R. BRINDLE, M.D.
JOSEPH R. JEHL, M.D.

Action: Page 19

APPENDIX C-1

REPORT OF REFERENCE COMMITTEE "C"

The committee approved the recommendation of the Board of Trustees of the following nominations for the Board of Governors, Medical Service Administration:

Harry N. Comando, M.D.	William F. Costello, M.D.
Arthur W. Lunn	Royal A. Schaaf, M.D.
Rudolph C. Schretzmann, M.D.	Edward W. Sprague, M.D.
John S. Thompson	Thomas J. White, M.D.

The committee approved the recommendation of the Board of Trustees of the following nominations for the Board of Trustees, Medical-Surgical Plan:

Charles W. Barkhorn, M.D.	Irving P. Borsher, M.D.
Harry N. Comando, M.D.	Patrick H. Corrigan, M.D.
William F. Costello, M.D.	Joseph P. Donnelly, M.D.
Joseph M. Keating, M.D.	Arthur W. Lunn
Paul Mcrayer, Jr., M.D.	Royal A. Schaaf, M.D.
Rudolph C. Schretzmann, M.D.	Edward W. Sprague, M.D.
John S. Thompson	Thomas J. White, M.D.

Carl K. Withers

The committee approved the resolution introduced by an Essex Delegate concerning Medical-Surgical Plan, which resolution follows:

WHEREAS, the Medical-Surgical Plan allows a greater fee for emergency services within forty-eight hours when these emergency services are performed in the outpatient department or the Emergency Ward of a hospital, as compared to a lesser fee allowed for the same emergency services when performed in a private physician's office, and

WHEREAS, the actual location where emergency services are performed is incidental when the same services are performed in the private physician's office as in the outpatient department or emergency ward of a hospital.

THEREFORE, BE IT RESOLVED, that the same fee be allowed by the Medical-Surgical Plan for emergency services when performed in the private physician's office as allowed in the outpatient department or emergency ward of a hospital.

The committee approved the resolution introduced by the Gloucester County Medical Society on the subject of group participation in New Jersey Blue Cross through the State Society, which resolution reads as follows:

WHEREAS, many of the members of the smaller county medical societies would like to enjoy the benefits of the New Jersey Hospitalization Plan as a group; and

WHEREAS, some smaller societies such as Gloucester have difficulty in enrolling the necessary 65 per cent to 70 per cent of their members in said Blue Cross Plan; and

WHEREAS, The Medical Society of New Jersey as a group could join the Blue Cross with only 50 per cent participation:

THEREFORE BE IT RESOLVED, that the House of Delegates here assembled request the Board of Trustees of the State Medical Society to investigate the possibilities of such a plan, with the mechanics of collections of premiums, etc., being left to the discretion of the Hospitalization Plan.

The report of the State Board of Medical Examiners was approved as published.

We approved the annual report of Medical Service Administration as published in the JOURNAL. The committee also approved the resolution of the Board of Governors, Medical Service Administration, submitted through the Board of Trustees of The Medical Society of New Jersey, on the subject of submission of Medical Service Plan to Congress, which reads as follows:

WHEREAS, the most urgent problem in the distribution of medical care is that relating to the provision of medical and hospital care for elderly and aged, disabled, physically and mentally handicapped, indigent, medically indigent, unemployable and unemployed persons for whom adequate medical and hospital care cannot be provided by established prepaid sickness insurance plans operated upon sound insurance principles; and

WHEREAS, medical and hospital care for such persons can be provided on a "cost-plus" or "reimbursement" basis through tax subsidies from tax funds administered on a local level by non-partisan, non-political and non-profit organizations, as has been demonstrated so clearly and convincingly by the Medical Service Administration of New Jersey in its operation of the City of Newark Plan for the provision of medical care to indigent and medically indigent; and

WHEREAS, the commendable objectives of President Eisenhower and the Secretary of Health, Education and Welfare, as set forth in proposed "reinsurance" legislation now before the Congress of the United States and sponsored by the Secretary of Health, Education and Welfare and her advisors, cannot possibly be attained without a huge subsidy by the Federal Government and without the risk of federal control of the insurance industry and the socialization of medicine; and

WHEREAS, Senator H. Alexander Smith and Congressman Charles A. Wolverton of New Jersey have demonstrated their interest in and concern for the attainment of a solution of the problem of the distribution of medical care by sponsorship of S. 3114 and H.R. 8356 respectively;

THEREFORE BE IT RESOLVED, that the attention of Senator Smith and Congressman Wolverton be drawn to the really pressing facets of the medical care problem and that they be urged to concentrate their attention and effort upon legislation designed to make adequate medical and hospital care available to indigent and medically indigent persons, and that these legislators be courteously reminded of the contribution already made by The Medical Society of New Jersey in the field of medical care of indigent and medically indigent persons by the establishment of the effectively functioning Medical Service Administration of New Jersey, and that The Medical Society of New Jersey offer to collaborate with Senator Smith, Congressman Wolverton and other legislators in the development of an appropriate and satisfactory bill designed to provide adequate medical and hospital care for the indigent and medically indigent; and

BE IT RESOLVED FURTHER, that copies of this resolution be forwarded to the President of

the United States, to the Secretary of Health, Education and Welfare, and to the Senators and Congressmen from New Jersey, Secretary and Chairman of the Legislative Committee of the A.M.A., and other appropriate agencies.

The committee approved the report of Medical-Surgical Plan as published in the JOURNAL. The supplemental report of the Plan was also approved, which report includes items on (1) Field Service Program; (2) Anesthesia Services and Participation of Anesthetists; (3) Legislation Relating to Optometrists and Chiropodists; (4) Tentative Date for Issuance of New Contract; (5) Communications from Subscriber Groups Regarding Proposed Contract Changes; (6) Federal Health Reinsurance Bill; (7) Blue Shield Plans Affirm Support of Service Benefit Principle.

The committee considered the report by the Special Committee on the Problem of Division of Fees under Medical-Surgical Plan, as submitted by Dr. John E. Leach, Chairman. After a thorough discussion of the report, it was used as part of the basis for the recommendations to be made later in this report by this committee concerning the division of fees.

The committee reviewed at great length the resolution by the Mercer County Medical Society and the Hudson County Medical Society on the subject of division of surgical fees by Medical-Surgical Plan. The committee did not approve the resolutions as presented, but used them as the basis for discussion and recommendations of the committee which appear later in the report.

Following a lengthy period of discussion of the problem of division of fees by Medical-Surgical Plan, the committee makes the following recommendations:

1. Any physician who assists in a medical, surgical, or obstetrical procedure is entitled to receive a fee commensurate with the services he renders.
2. The determination of eligibility of an assistant in a medical, surgical, or obstetrical procedure shall be the direct responsibility of the hospital service concerned.
3. It is the opinion of the committee that the fee schedule as listed by Medical-Surgical Plan for a surgical procedure is an all-inclusive fee, and does not represent the fee for the operative procedure alone. Therefore, the committee recommends that the total fee for the procedure be reapportioned, and that a new schedule of fees be established to provide payment for adequate and active pre-operative and post-operative care and for the technical assistance at the operative procedure itself as well as for the operative procedure.
4. Each physician who participates actively in the care of a patient shall send his bill for services separately to the Medical-Surgical Plan for payment.

KENNETH E. GARDNER, M.D.
Chairman
HARRY W. FULLERTON, JR., M.D.
EMANUEL M. SATULSKY, M.D.

Action: Pages 19 to 32

APPENDIX C-2

MINORITY RECOMMENDATIONS OF REFERENCE COMMITTEE "C"

GEORGE A. CORIO, M.D., Trenton

1. I agree with recommendation No. 1.
2. I agree with recommendation No. 2 with this addition—"that the eligibility conform in accordance with the recommendations of the Joint Committee on Accreditation of Hospitals. Personnel of each service shall be qualified by training and demonstrated competence and shall be granted privileges commensurate with their individual ability."
3. I disagree with recommendation No. 3 in toto. I recommend that the fee made payable to the assistant be in addition to that already allocated to a medical, surgical, or obstetrical procedure, and to include pre- and postmedical, surgical, or obstetrical care.
4. I agree with recommendation No. 4.

Action: Pages 20 and 21

APPENDIX D

REFERENCE COMMITTEE "D"

C. ARCHIE CRANDELL, M.D., Chairman

Reference Committee "D" met on Monday morning, May 17, 1954, with all members present. Also present were Dr. Decker, Dr. Fritts, Dr. Trussell and Dr. Saffron.

The committee had for its consideration the reports of the Medical Defense and Insurance Committee, the Emergency Medical Service, Civil Defense Committee, the Medical Education Committee, the Medical School Committee, the Physicians Placement Service Committee and the Medical Research Committee.

The Reference Committee favored the recommendations of the Medical Defense and Insurance Committee, including the continuance of Faulhaber & Heard, Inc., as official broker for The Medical Society of New Jersey. It also felt the State membership should be polled in order to secure accurate data as to the amount of coverage carried, suits or claims that have occurred, the name of the insurance carrier, and the source through which the policy has been obtained.

The report of the Committee on Medical Education was received and the committee favors the continuance of this committee in its graduate education efforts.

The report of the Medical School Committee was received and the continuance of its work to establish a medical school in this State was urged.

The reports of the Emergency Medical Service, Civil Defense Committee, the Physicians Placement Service Committee, and the Medical Research Committee were approved as received.

Respectfully submitted,

C. ARCHIE CRANDELL, M.D.,
Chairman
MILLARD CRYDER, M.D.
LLOYD A. HAMILTON, M.D.
RALPH M. L. BUCHANAN, M.D.
FRANK J. HUGHES, M.D.

Action: Pages 32 and 34

APPENDIX E

REFERENCE COMMITTEE "E"

ROBERT N. BOWEN, M.D., Chairman

Reference Committee "E" met on May 17, 1954, with all members present.

The reports of the Welfare Committee, the subcommittees of the Welfare Committee, and the advisory committees to the subcommittees were all approved with the exceptions of:

1. Advisory Committee on Workmen's Compensation and Industrial Health. The feeling of the committee was (a) the paucity of information made it impossible to render an intelligent opinion; and (b) the problem appeared to be one for local county option.

2. The Special Report on the Relationship between Osteopaths and Medicine. This report was discussed in the greatest of detail by the entire committee, who were also benefited by the first-hand information of our A.M.A. delegates and two of the officers of the Society. The considered opinion of the committee was (a) the conclusions of the poll are likely based on inadequate information and/or insufficient study by the individual voting members of the several county societies; and (b) five county societies failed to report in the poll for reasons unknown. Unfortunately, too, amongst the five non-reporting counties were two of the largest in the state. Thus it was felt the poll could not be viewed in any conclusive way as demonstrative of an accurate tabulation of opinion.

Following the deliberations, the committee strongly suggests that the A.M.A. delegates from the State of New Jersey be uninstructed as we have full confidence in their judgment. It was also the consensus that further matters of information may come to our delegates in the interim between now and the A.M.A. convention.

The Union County "Resolution Opposing the Expansion of Social Security and the Inclusion of Physicians in the Social Security System" was unanimously approved.

The Union County resolution on H.R. 6949 and H.R. 8356 and S. 3114 was unanimously approved by the committee.

The Union County resolution supporting the proposed 23rd amendment was unanimously approved.

The Union County "Resolution Supporting the Action to Determine the Position of all Candidates on the Bricker Amendment and the Proposed 23rd Amendment" was unanimously approved.

The Union County resolution on H.R. 6950 was unanimously approved.

Respectfully submitted,

ROBERT N. BOWEN, M.D.,
Chairman
MORTON L. POYAS, M.D.
G. RUFFIN STAMPS, M.D.
LEON E. DEYOE, M.D.
THOMAS S. P. FITCH, M.D.

Action: Page 32

APPENDIX F

REFERENCE COMMITTEE ON CONSTITUTION
AND BY-LAWS

MORRIS H. SAFFRON, M.D., Chairman

The following constitutional amendment, having received the approval of the Committee on Revision of the Constitution and By-Laws, was considered by the Reference Committee on Constitution and By-Laws at its meeting on May 17. In accordance with the constitutional provision covering amendments the proposal will be published in the JOURNAL of the Society and officially sent to each component society at least three months before the next annual meeting, at which final action will be taken.

CONSTITUTION, ARTICLE IV, SECTION 5 —
HONORARY MEMBERS

Honorary members shall be physicians and surgeons who have attained distinction within the medical profession or non-medical persons who have rendered signal service to The Medical Society of New Jersey or who have attained special eminence in scientific fields other than medicine.

Nominations shall be submitted by recognized medical groups to the Committee on Honorary Membership for approval or disapproval, and the committee's action shall be transmitted to the Board of Trustees by December first. Nominations approved by the Board of Trustees shall be officially sent to the component county medical societies at least three (3) months before the annual meeting at which action is to be taken, and the approval of a majority of the component county medical societies shall be required to validate the nomination before it can be submitted to the House of Delegates. Nominees may be elected by a two-thirds vote of the House of Delegates provided the number of living Honorary Members does not exceed fifteen (15). Presentation of the honorary membership shall be made at the following annual meeting. Honorary Members shall have all the privileges of members, but shall not be members of the corporate body.

The Reference Committee approves the above proposed amendment to the constitution and recommends that it follow the procedure required.

MORRIS H. SAFFRON, M.D.,
Chairman
J. HOWARD HORNBERGER, M.D.
VINCENT A. BURELL, M.D.

Action: Page 32

APPENDIX G

REFERENCE COMMITTEE ON
MISCELLANEOUS BUSINESS

JOHN P. COUGHLIN, M.D., Chairman

The Reference Committee on Miscellaneous Business met at 2:00 p.m. on Monday, May 17, 1954. All members were present.

1. The committee accepts the recommendation of the Board of Trustees that the next annual meeting be held at the Ambassador Hotel, Atlantic City, New Jersey, April 17-20, 1955.

2. The committee moves the acceptance of the report of the Scientific Program Committee, namely, "Each section shall limit itself to two out-of-state speakers. No section shall expend more than \$100 for the expenses of its speakers."

3. The committee accepts the report of the Advisory Committee to the Woman's Auxiliary.

5. This committee approves the resolution introduced by Dr. Brodtkin of Essex County on "Rehabilitation".

6. The committee approves the resolution introduced by the Sussex County Medical Society on "Tests for Drunken Driving".

We recommend further that this be referred to the Medical Legal Liaison Committee.

Respectfully submitted,

JOHN P. COUGHLIN, M.D.,
Chairman
BAXTER H. TIMBERLAKE, M.D.
A. GUY CAMPO, M.D.
CHARLES H. CALVIN, M.D.
BERNARD M. HALBSTEIN, M.D.

Action: Pages 32, 33 and 34

APPENDIX H

REPORT OF THE REFERENCE COMMITTEE ON RESOLUTIONS AND MEMORIALS

R. J. COTTONE, M.D., Chairman

There were no new names submitted to the committee for election to *Honorary Membership* in The Medical Society of New Jersey. I am in complete accord with the proposed amendment to the Constitution as proposed by the Board of Trustees which requires approval of the nominee by the county medical societies before the nomination is brought before the House of Delegates.

The following nominations for election to Emeritus Membership at the 1954 Annual Meeting have been received from the county medical societies:

Camden County—Dr. William G. Shemeley, Jr., Darby, Pa., formerly Camden; age 67; retired because of ill health; member in good standing since 1933. Approved.

Essex County—Dr. Edwin J. Kaderabek, New Smyrna Beach, Fla., formerly East Orange; age 58; retired because of ill health; member in good standing for over twenty years. Approved.

Essex County—Dr. Elizabeth Brakeley, Montclair; age 60; retired from practice; member in good standing for over twenty years. Approved.

Essex County—Dr. H. Garrett Vander Veer, Skaneateles, N. Y., formerly Bloomfield; age 57; retired from practice; member in good standing for over twenty years. Approved.

Essex County—Dr. H. Roy Van Ness, Newark; age 68; retired because of ill health; member in good standing for over twenty years. Approved.

Essex County—Dr. Adam H. Friedrich, Manasquan, formerly Newark; age 60; retired from practice; member in good standing for over twenty years. Approved.

Essex County—Dr. Henry E. Ricketts, Newark; age 77; retired because of age; member in good standing for over twenty years. Approved.

Essex County—Dr. Gustav A. Braun, East Orange; retired because of age; member in good standing for over twenty years. Approved.

Morris County—Dr. George J. Young, Morristown; age 56; retired because of ill health; member in good standing for over twenty years. Approved.

Your Committee considered the implementation of a resolution offered by the Hudson County Medical Society and adopted last year by our House of Delegates. This was the resolution which disapproved of hospitals that made staff privileges contingent on "voluntary" cash donations to the hospitals. This resolution called for a thorough investigation of such charges by the Medical Society and for a definitive and punitive action against hospitals found guilty. It was the opinion of the investigating committee (the Advisory Committee on Hospital Relationships) that no action can be taken, especially punitive action, against hospitals unless there are specific allegations brought forth by a group of physicians or a county society, so that legal steps may be taken.

The committee suggested the desirability of establishing a test case and bringing this matter to a decisive conclusion. So far as we know, no such test case has come forward.

All members of the committee attended the meeting. Dr. L. Samuel Sica, representing the Board of Trustees, also attended the meeting.

Respectfully submitted,

R. JOHN COTTONE, M.D.,
Chairman
WINTON H. JOHNSON, M.D.
LORIMER B. ARMSTRONG, M.D.

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The New York Academy of Medicine

DUE IN TWO WEEKS UNLESS RENEWED.

NOT RENEWABLE AFTER 6 WEEKS.

DATE BORROWED	BORROWER
NOV 7 - 1957	Boyle, Robert
NOV 1	Curtis
SEP 27 1950	V. A. Brown
DEC 20 1961	Howard



